Medicaid Payment & Delivery System Innovation: Integrated Health Partnerships

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Overall Health System Performance

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.
What’s the context?
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)
What’s the context?

MN’s Health Reform Building Blocks: Foundation

- Medicaid
- ACOs
- Health Care Homes
- SHIP
- Strong Collaborative Partnerships
- Standardized Quality Measurement
- E-health Initiative
- Community Care Teams
What’s SIM and what are we trying to answer?

<table>
<thead>
<tr>
<th>Can we improve health and lower costs if more people are covered by Accountable Care Organizations (ACO) models?</th>
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<tbody>
<tr>
<td>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?</td>
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<td>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?</td>
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</table>
How will MN achieve SIM goals?

- Build on existing reforms
- Invest in e-Health (health information technology and exchange), data analytics, workforce and practice transformation
- Create up to 15 Accountable Communities for Health
- Accelerate adoption of ACOs, specifically expanding Minnesota's Medicaid IHP demonstration
What is an Accountable Care Organization (ACO)?

- A group of health care providers with collective responsibility for patient care that helps coordinate services – deliver high quality care while holding down costs

- Creates an incentive through a variety of payment structures for providers to efficiently and effectively manage the full spectrum of care a patient receives throughout the care system

- Innovation lies in the flexibility of their structure, payments and risk assumptions
What is Minnesota’s approach to Medicaid ACO development?

- **Integrated Health Partnership (IHP) demonstration** – Predates SIM; authorized in 2010 by Minnesota Statutes, 256B.0755

- Builds on a long history of health reform – wanted to 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 that drive rapidly away from the incentive “to do more” and towards increasing levels of integration
  - “Locus of care” provider responsible for patient pops’ overall health
  - Accountability for patients’ **total cost of care (TCOC)**
  - Robust and consistent **quality measurement**
Who can be an IHP? 
Provider 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?
Same Framework, Multiple Model Options

• Providers voluntarily contract with DHS under two broad model options: **Integrated** or **Virtual**

• **Flexibility** within these two models to accommodate provider makeup, size and capacity, and risk tolerance with the goal to ensure broadest possible participation.

  - **Integrated** = Delivery system providing spectrum of care as a common entity; move toward symmetrical “downside” risk; can propose variable risk corridors and distributions (doesn’t have to be 50/50)

  - **Virtual** = collaborative, not affiliated with a hospital, or serving <2000 enrollees; “up-side” only; savings beyond min. threshold shared 50/50
How are IHPs Accountable?
Total Cost of Care (TCOC)

- Existing provider payment persists during the Demo.
- **Medicaid recipients** (under 65, not dually eligible) - across both FFS and managed care organizations - attributed using past encounters/claims
- **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 (across core set of services) to subsequent years.
How do we calculate TCOC shared savings?

Integrated Model Example

- 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 does the Virtual Model differ for TCOC?

- No downside risk but similar TCOC target development; comparison to actual performance to determine cost savings.

**GAIN:**
Savings achieved beyond the minimum threshold are shared between the payer and delivery system 50/50.
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

- Wanted to created a **baseline of actionable reports** for all IHPs, while enabling IHPs the opportunity to **integrate, enhance and expand** use of data

- **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

- **IHP Portal Analytical Reports (“Cooked” SAS BI Reports)**

- **Quarterly Data User Groups** – IHPs influence, provide feedback on reports and data available

- **SIM Data Analytics Grants** - $4m total across 11 IHPs; $$s used to enhance individual analytics capacities
How do we help the IHPs succeed?

Reporting and Data Feedback – SAS BI Reports

- IHP Portal Analytical Reports (SAS BI Reports)
  - 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
  - Utilization
    - Risk adjusted ED and Inpatient trends
    - Pharmacy – broken down by drug class, highlights specialty drugs
  - Quality
    - HEDIS measures
    - Clinical and hospital SQRMS measures
  - 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
How do we help the IHPs succeed?

SAS BI Portal Desktop Snapshot

- 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
- Attributed 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
What does the IHP demo look like right now?

Consistent growth

MN Integrated Health Partnerships Growth

ACOs = 6
Enrollees = 99,107
Providers = 2,739

ACOs = 9
Enrollees = 145,869
Providers = 7,328

ACOs = 16
Enrollees = 204,119
Providers = 8,892

ACOs = 19
Enrollees = 342,314*
Providers = 8,892
What does the IHP demo look like right now?

11 Integrated IHPs

<table>
<thead>
<tr>
<th>IHP</th>
<th>Geographic area</th>
<th>Size (# Attributed)</th>
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</thead>
<tbody>
<tr>
<td>Allina Health*</td>
<td>Greater Minnesota</td>
<td>62,107</td>
</tr>
<tr>
<td>CentraCare*</td>
<td>Central MN, N of Mpls/SP</td>
<td>22,961</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>Minneapolis/St. Paul</td>
<td>22,142</td>
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<tr>
<td>Essentia Health*</td>
<td>Duluth/NE MN</td>
<td>43,906</td>
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<tr>
<td>Hennepin Healthcare System/HCMC</td>
<td>Minneapolis/St. Paul</td>
<td>38,998</td>
</tr>
<tr>
<td>Lake Region Healthcare*</td>
<td>West Central MN</td>
<td>4,776</td>
</tr>
<tr>
<td>Lakewood Health System*</td>
<td>Central MN</td>
<td>4,572</td>
</tr>
<tr>
<td>Mayo Clinic</td>
<td>Rochester/SE MN</td>
<td>3,175</td>
</tr>
<tr>
<td>North Memorial</td>
<td>Minneapolis/St. Paul</td>
<td>20,045</td>
</tr>
<tr>
<td>Northwest Health Alliance (Allina/HealthPartners)</td>
<td>Minneapolis/St. Paul</td>
<td>19,342</td>
</tr>
<tr>
<td>Winona Health*</td>
<td>Winona/SE MN</td>
<td>5,022</td>
</tr>
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</table>

* IHPs that include rural health providers
What does the IHP demo look like right now?

8 Virtual IHPs

<table>
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<tr>
<th>IHP</th>
<th>Geographic area</th>
<th>Size (# Attributed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bluestone Physician Services</td>
<td>Minneapolis/St. Paul</td>
<td>~1,000</td>
</tr>
<tr>
<td>Courage Kenney (Allina Health)</td>
<td>Minneapolis/St. Paul</td>
<td>1,933</td>
</tr>
<tr>
<td>FQHC Urban Health Network (10 FQs)</td>
<td>Minneapolis/St. Paul</td>
<td>33,256</td>
</tr>
<tr>
<td>Gillette Children’s Specialty Healthcare*</td>
<td>Greater Minnesota</td>
<td>~1,000</td>
</tr>
<tr>
<td>Integrity Health Network*</td>
<td>NE MN</td>
<td>9,346</td>
</tr>
<tr>
<td>Mankato Clinic</td>
<td>Mankato</td>
<td>9,814</td>
</tr>
<tr>
<td>Southern Prairie Community Care*</td>
<td>Marshall/SW MN</td>
<td>28,509</td>
</tr>
<tr>
<td>Wilderness Health*</td>
<td>NE MN</td>
<td>11,660</td>
</tr>
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* IHPs that include rural health providers
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 (interim) settlements ($22.7 million in total)
What are IHPs saying about the program?

Participation can accelerate care delivery innovations that had already begun, such as movement towards team-based care, community partnerships, a “super-utilizer” focus, etc.

**BUT... Innovations can be costly**, particularly upfront costs – modifying care systems, data analytic supports, staffing, is expensive, and potential shared savings may be years away. Continued shared savings isn’t always possible.

**Flexibility of model is key** - every population is different; everything is local.

**BUT... Not all providers fit** well into the current demonstration.

**Data and reports have been essential**, providing a “source of truth” and a view of patients not readily available elsewhere.

**BUT... Data rich, but sometimes still information poor.**

Variations in capacities across IHPs, not always able to use the data effectively. **Timing of data** can make it’s use difficult

Patient attribution is retrospective, so it’s based on a patient’s and provider’s actual experience.

**BUT... There’s still a lot of “churn,”** making it difficult to track individual patients for care coordination. Attribution doesn’t work equally for all types of providers.
What are our take-aways?

- **Stabilize payment support** for care coordination and infrastructure development (for example through a consolidated prospective payment) – smaller providers may be at a disadvantage to absorb upfront costs.

- Continued **data supports are key** to success; continue to work with participants in making reports more readily actionable.

- 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.
What’s next?

- Seek additional stakeholder feedback - **RFI anticipate in early spring 2016**
- Incorporate feedback to develop **advanced model track (IHP 2.0)**
- Explore **Medicare/Medicaid Integrated ACO** model for under 65 duals
- Emphasis on **wider 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
- Identify financing methods that **support IHPs’ upfront infrastructure needs**
- Work across **payer community to align models** where appropriate
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