Medicaid Payment and Delivery System Reforms: Minnesota's Experience

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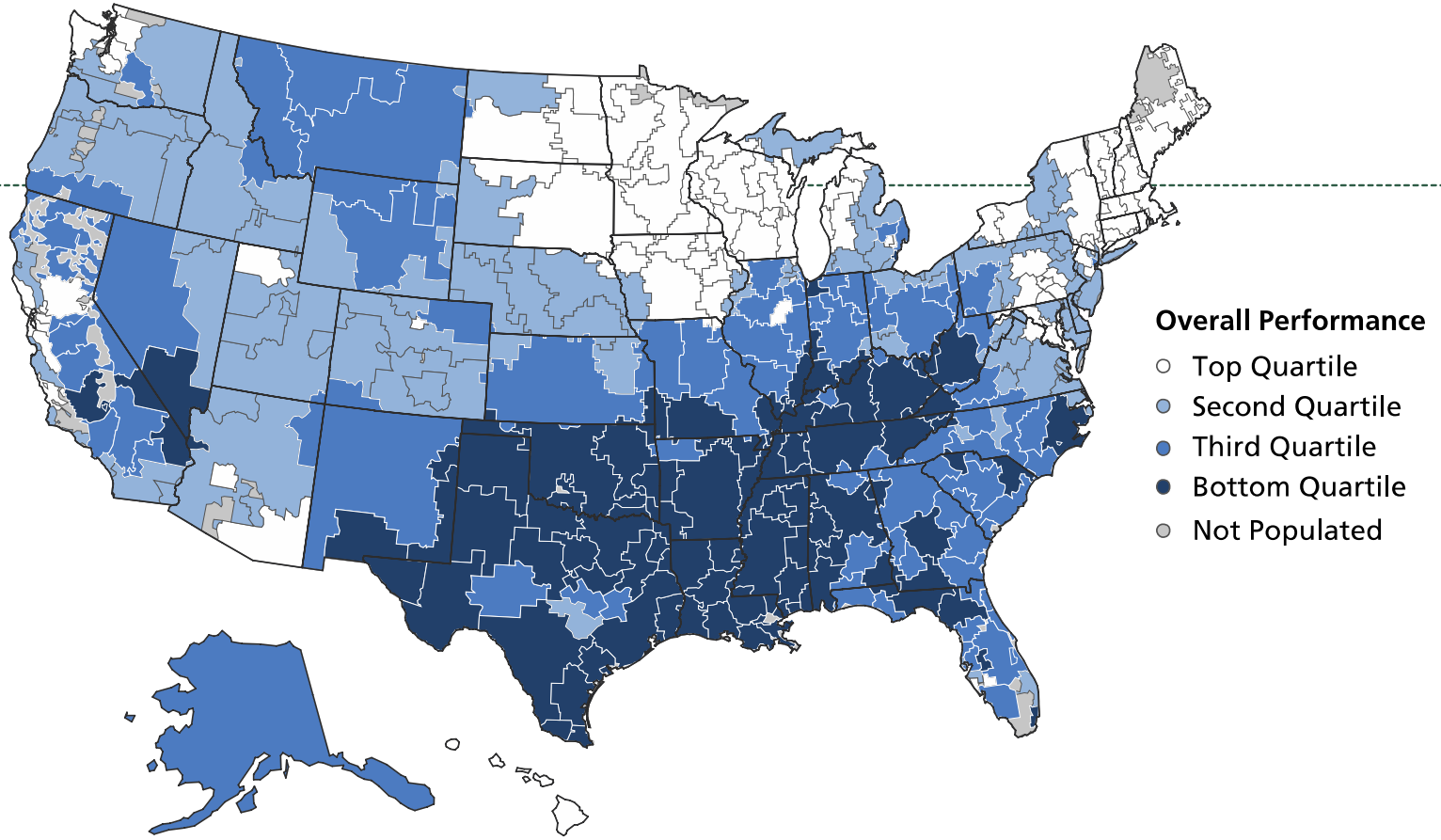
health reform MINNESOTA
A Better State of Health

Overview

- A little Minnesota context
- Past Minnesota building blocks to accountable care
- Minnesota's Medicaid Accountable Care Efforts
  - Integrated Health Partnerships - Formerly Health Care Delivery System (HCDS) Medicaid ACO Demo
  - Hennepin Health
- Lessons Learned so far
- Next steps

Overall Health System Performance



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

Minnesota's Medicaid programs

- Medical Assistance – Minnesota's Medicaid program – approximately 609,000 enrollees
  - Large majority enrolled in managed care plans
- MinnesotaCare – subsidized state program – approximately 131,000
  - All managed care
- MA is the supplement to Medicare for approximately 106,600 Minnesotans who are dual eligibles
  - Mostly managed care

Minnesota's Approach to Medicaid ACO development

- Define the "what" we seek, rather than the "how"
- Provide multiple opportunities for innovation under a framework of several models
- Allow for local flexibility and innovation under a common framework of accountability
- Framework of accountability includes:
  - Models based on, and with accountability for, total cost of care
  - Robust quality measurement
  - Models that drive rapidly away from the incentive "to do more"
  - Models that drive rapidly towards increasing levels of integration

Two Examples

- Minnesota Medicaid ACO model: Integrated Health Partnerships (IHP)
  - Formerly Health Care Delivery System Demo (HCDS)
- Hennepin Health: a Safety Net ACO

Two Examples

Minnesota Medicaid ACO model:

Integrated Health Partnerships (IHP)

Authorizing legislation for Minnesota' Medicaid ACO Demonstration: IHP

"The Minnesota Department of Human Services shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."

(Minnesota Statutes, 256B.0755)

IHP Process and Timeline

- Started with an RFI process, to gather input
- Developed and issued initial RFP in summer 2011
- Responses received were broadly representative of geographic and organizational structure
- 6 provider systems, serving 100,000 Medicaid enrollees, started in our IHP model in January 2013
- 3 additional provider systems began in 2014, for a total of 145,000 Medicaid enrollees currently being served
- Released an updated RFP in February 2014 seeking additional providers to begin in January 2015

Minnesota's Medicaid ACO Demo (IHP): 145,000 enrollees total

Proposer	Geographic area
CentraCare	Central MN, north of Minneapolis/St. Paul
Children's Hospital	Minneapolis/St. Paul
Essentia Health	Duluth/NE MN
FQHC Urban Health Network (10 FQs)	Minneapolis/St. Paul
Hennepin Healthcare System/HCMC	Minneapolis/St. Paul
Mayo Clinic	Rochester/SE MN
North Memorial	Minneapolis/St. Paul
Northwest Health Alliance (Allina/HealthPartners)	Minneapolis/St. Paul
Southern Prairie Community Care	Marshall/SW MN

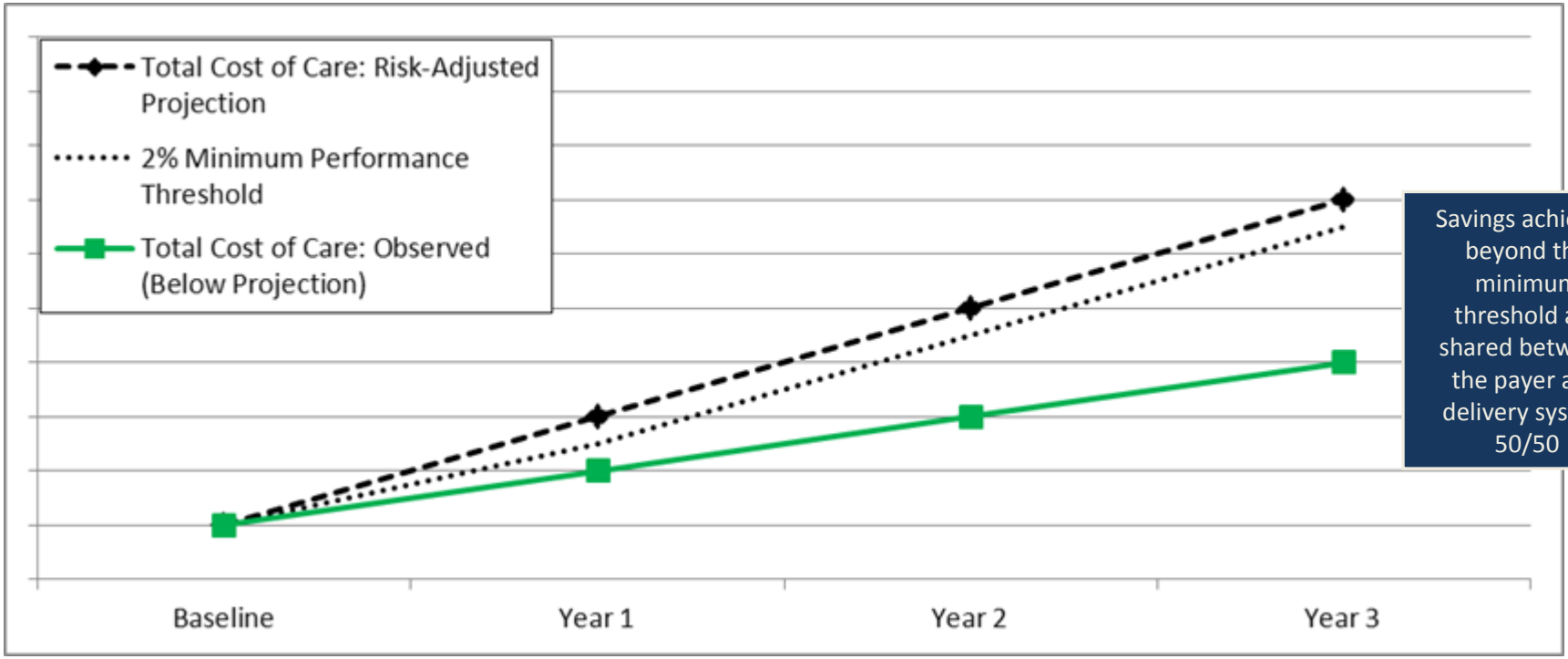
Payment Models and TCOC

Accountability for Total Cost of Care (TCOC)

- Medicaid recipients attributed to IHP for inclusion in TCOC Calculations
  - Both fee-for-service (FFS) and managed care (MCO) recipients attributed using past provider encounters
- Defined core set of services included in TCOC calculation; IHP may elect to include additional services
- Existing provider payment persists during the Demo, with gain-/loss-sharing payments made annually based on risk-adjusted TCOC performance
  - Contingent on quality performance

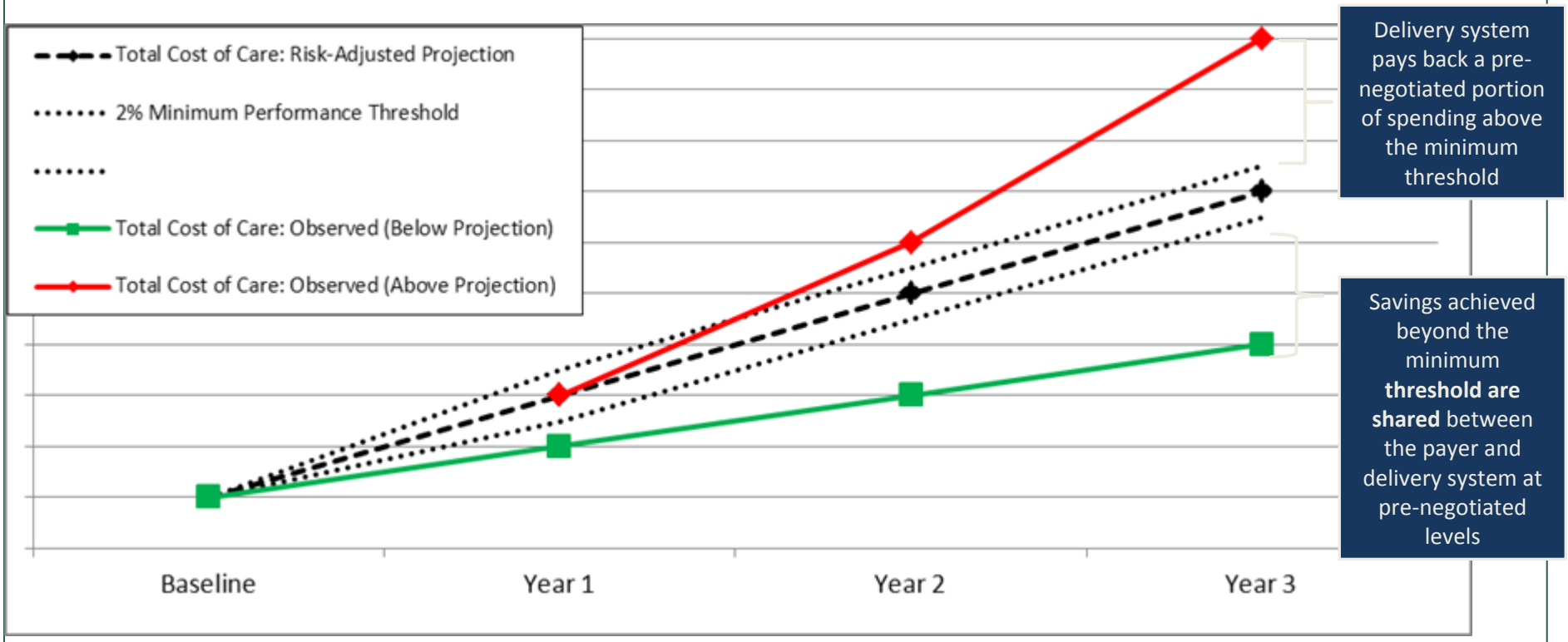
Model 1: Virtual Model (two IHPs)

- Primary care organizations not affiliated with a hospital or integrated system (or any IHP serving 1,000-2,000 attributed enrollees)



Model 2: Integrated Model (seven IHPs)

- Integrated delivery systems providing a broad spectrum of care as a common entity



Shared savings contingent on quality performance

- Core measure set includes **7 clinical measures** and **2 patient experience measures**, totaling 32 individual measure components – across both **clinic** and **hospital** settings
- Core set of measures based on existing state reporting requirements – Minnesota's **Statewide Quality Measurement and Reporting System**
  - IHPs have flexibility to propose alternative measures and methods
- Impact of quality measures on potential shared savings increases across the 3 years of the demonstration
  - 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

Shared savings contingent on quality performance

- Each individual measure is scored based on either achievement or year-to-year improvement
  - Achievement – Sliding scale between 30th percentile minimum attainment threshold (0 points) and 80th percentile upper threshold (2 points)
  - Improvement – Sliding scale based on relative improvement between 5% (1 point) and 10% (2 points)

- Quality performance score impacts shared savings payment
  - For example, in year 3 of the contract, 50% of payment based on TCOC performance and 50% is at risk depending on the overall quality score

Reporting and Data Feedback

- Quarterly Total Cost of Care exhibits
  - 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
- 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 Attributed Recipient-Level Reports
  - Comprehensive Care Management - ACG© Clinical Profile includes risk stratification, chronic condition and coordination of care indices
  - Provider Alert – Attributed recipients with an ED visit or hospital admission claim received in the prior month

Two Examples

Hennepin Health: A Medicaid ACO focused on Minnesota's early Medicaid expansion population (<133% FPG)

Hennepin Health: integration with social services and behavioral health

- "Safety net ACO"
- Population focus: adults on Medicaid with incomes below 133% FPG
- 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 that are frequent users of county services
- Incentives aligned under county-run safety hospital and clinics, HMO, FQHC, behavioral health, and other traditional county services.

A few lessons learned so far

- Work on the foundational elements needed for providers to take on risk:
  - Better data to manage total costs
  - Learning collaboratives and practice facilitation
  - Free up provider resources to reform care delivery
- Iterative change and testing; flexibility key
- Medicaid populations less stable than Medicare
- Risk adjustment and social complexity
- Quality measures, while on a relative scale robust in Minnesota, still need additional work on functional status and for Medicaid populations
- True integration across silos is doable, but requires infrastructure investment, trust, and experience

Moving Forward:

- Minnesota awarded a SIM testing grant which builds on IHP
- Expansion to additional populations (duals, complex)
- Strong emphasis on integration of acute care and other care settings and home and community based services/social services
  - More global community responsibility
- Patient choice versus provider interest in assignment
- Working to align purchasing with state employee group and with large self-insured Minnesota purchasers
  - Directional payment alignment; focus on data and provider feedback
- Learning lessons from the Hennepin Health demo
  - With interest in statewide applicability

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