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 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**.
- Performance compares each IHP’s base year TCOC (across core set of services) 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 (Integrated only).

[Graph showing projected and observed costs over years with lines indicating minimum performance threshold and savings above it.]
How else are IHPs Accountable?
Quality Measurement

- Performance on quality measures impacts the amount of shared savings an IHP can receive; phased in over initial 3-year program period
  - Year 1 – 25% of shared savings based on reporting only
  - Year 2 – 25% of shared savings based on performance
  - Year 3 and beyond – 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 (when possible)
How do we help the IHPs succeed?

Reporting and Data Feedback

- **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)**
  - Care Coordination
  - Utilization
  - Quality
  - Total Cost of Care

- **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
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?

Geographic spread

IHP membership by round

Round 1

Round 2

Round 3

Data Source: 3M; MN DHS Medicaid Data 1/2014-12/2014, claims paid through 7/2015.
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>
</tr>
</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>
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<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>
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<tr>
<td>Hennepin Healthcare System/HCMC</td>
<td>Minneapolis/St. Paul</td>
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<tr>
<td>Lake Region Healthcare*</td>
<td>West Central MN</td>
<td>4,776</td>
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<tr>
<td>Lakewood Health System*</td>
<td>Central MN</td>
<td>4,572</td>
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<tr>
<td>Mayo Clinic</td>
<td>Rochester/SE MN</td>
<td>3,175</td>
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<tr>
<td>North Memorial</td>
<td>Minneapolis/St. Paul</td>
<td>20,045</td>
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<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>
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* IHPs that include rural health providers
What does the IHP demo look like right now?  
8 Virtual IHPs

<table>
<thead>
<tr>
<th>IHP</th>
<th>Geographic area</th>
<th>Size (# Attributed)</th>
</tr>
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<tbody>
<tr>
<td>Bluestone Physician Services</td>
<td>Minneapolis/St. Paul</td>
<td>~1,000</td>
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<tr>
<td>Courage Kenney (Allina Health)</td>
<td>Minneapolis/St. Paul</td>
<td>1,933</td>
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<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>
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<tr>
<td>Integrity Health Network*</td>
<td>NE MN</td>
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<tr>
<td>Mankato Clinic</td>
<td>Mankato</td>
<td>9,814</td>
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<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>
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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)

- **Final 2014, interim 2015 results** due June 2016
What’s next?

- Continue current model, enabling additional provider systems to join January 2017– **Round 5 RFP published April 25th**
- Explore **Medicare/Medicaid Integrated ACO** model for under 65 duals
- Seek stakeholder feedback to develop advanced model tracks (IHP 2.0) - **RFI published April 18th**
Questions?

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