DEPARTMENT OF HUMAN SERVICES

Integrated Health Partnerships Program

Topics to cover today

+ National landscape in payment reform
+ Payment reform beginnings in Minnesota
+ Today's Integrated Health Partnerships (IHP)
+ The IHP model
+ IHP 2.0
+ IHPs moving forward

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National landscape in payment reform and accountable care organizations

What is the Current ACO Market?

Rapid expansion across payers

- Over 800 ACOs in the United States

Over 25 million covered lives

- Commercial: 17.2 million
- Medicare: 8.3 million
- Medicaid: 2.9 million

Widespread penetration

- ACO service areas in all 50 states and the District of Columbia

Federal Policies and Promising Results Support Building Momentum for ACOs

- ACOs are a key vehicle in the industry-wide shift from fee-for-service to value-based purchasing
- Providers are increasingly likely to seek opportunities to join "advanced" alternative payment models (including certain types of ACOs) under MACRA*
- ACOs tend to show greater focus on population health, wellness, and disease prevention
- **Many ACOs have shown cost reductions and quality improvement**

HHS Value-Based Payment Goals

2016

☑ 30% of Medicare payments tied to alternative payment models, such as ACOs or bundled payments (HHS met this goal)

2018

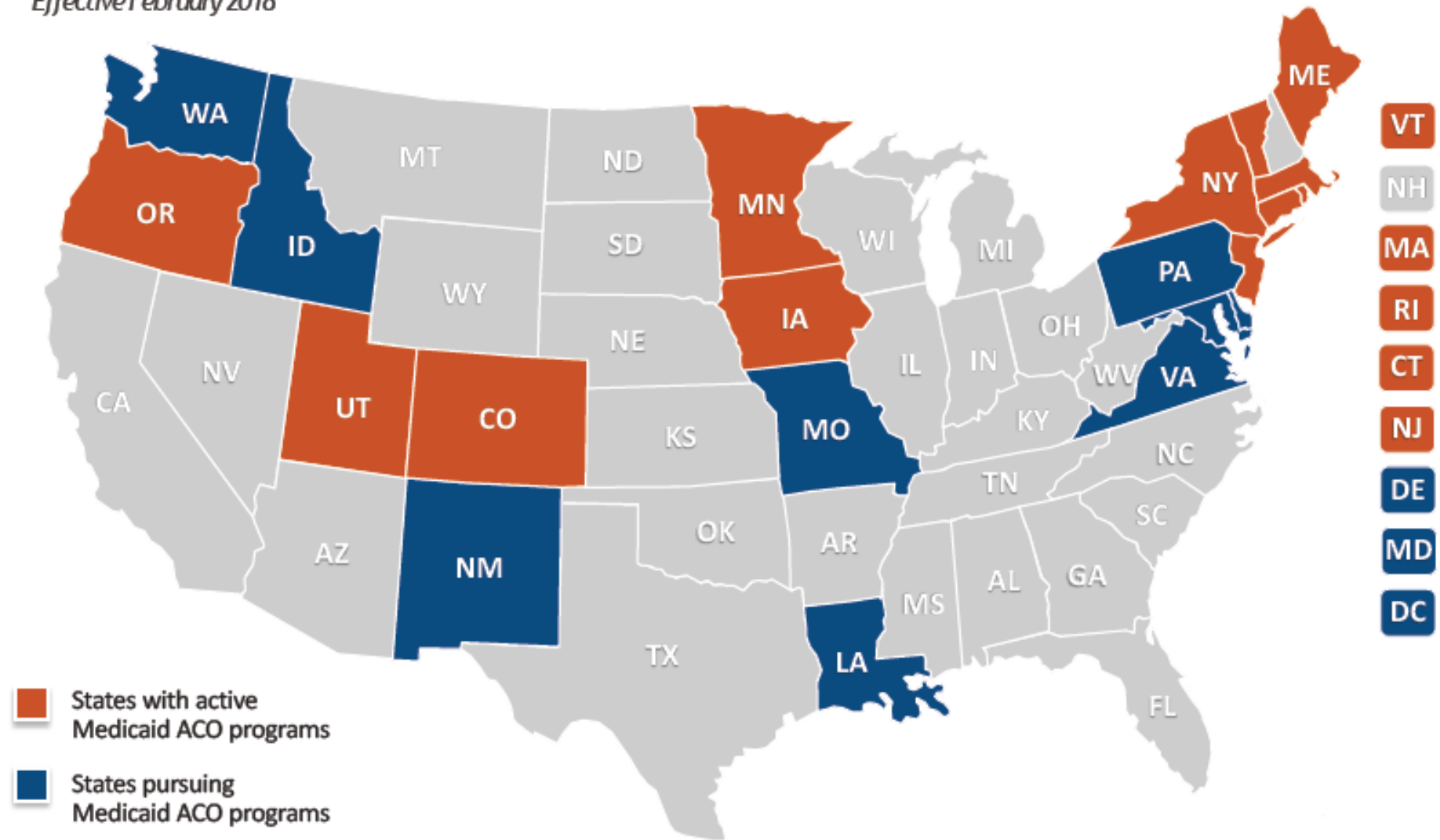
☐ 50% of Medicare payments tied to alternative payment models

ACO Programs at the Centers for Medicare & Medicaid Services (CMS)

- Medicare Shared Savings Program
  - For fee-for-service beneficiaries
- ACO Investment Model
  - For Medicare Shared Savings Program ACOs to test pre-paid savings in rural and underserved areas
- Advance Payment ACO Model
  - For certain eligible providers already in or interested in the Medicare Shared Savings Program
- Comprehensive End Stage Renal Disease Care Initiative
  - For beneficiaries receiving dialysis services
- Next Generation ACO Model
  - For ACOs experienced in managing care for populations of patients
- Pioneer ACO Model
  - For health care organizations and providers already experienced in coordinating care for patients across care settings

State Medicaid Accountable Care Organization Programs

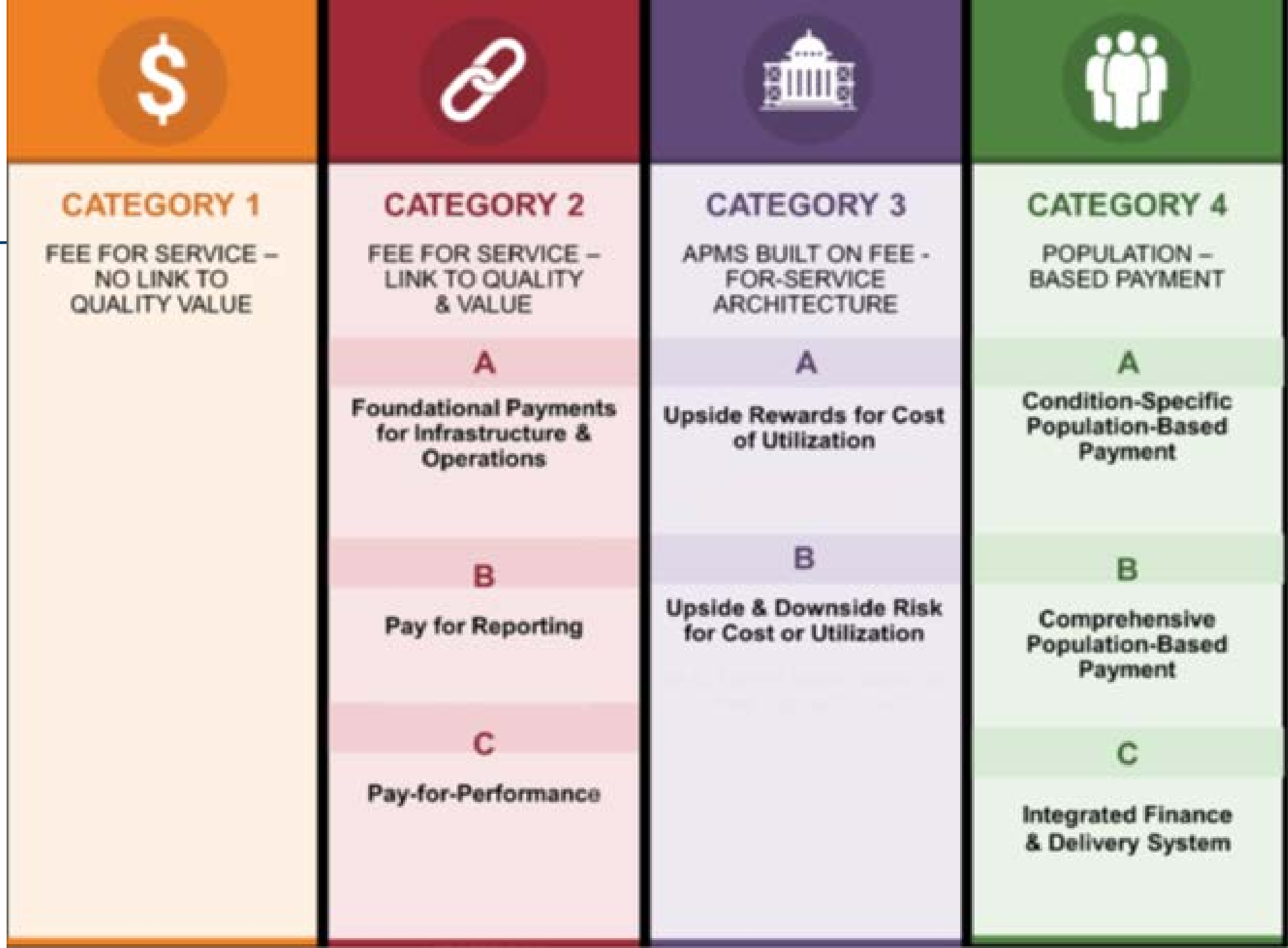
Effective February 2018



CATEGORIES OF PAYMENT REFORM

The Centers for Medicare & Medicaid Services (CMS)

Multi-payer Learning Action Network (LAN)



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Payment reform & IHP beginnings

"Health care payment systems must be restructured to support and encourage evidence-based, high-value health care. The Task Force recognizes that current payment systems do not support innovation that improves quality and reduces cost – in fact, sometimes current systems penalize providers that do a good job of managing care.

"**The way we pay for health care must be fundamentally changed in ways that support improvements in quality and establish accountability for the total cost of care."**

2007 Governor's Health Care Transformation Task Force Core Recommendations

Level 1: **Tie payment to quality and efficiency of care**
Level 2: **Pay for care coordination (Health Care Homes)**
Level 3: Establish a system of accountability for the total cost of care

- Provider groups and care systems **compete for patients** by submitting bids on the total cost of care for a given population.
- **Patients choose provider groups** and care systems based on cost and quality
- **Payments to providers are risk-adjusted** based on the health of the population they manage
- Level 3 providers also **accountable for quality**
- Because providers share in any savings they achieve, providers would have **incentives to innovate and compete** on ways to better manage population health

2007 Task Force recommendations on payment reform

The approach: Medicaid ACO development in Minnesota

- Builds on a long history of reform in Minnesota (2008)
  - Health Care Homes
  - E-health Initiative
  - Encounter Data Collection
  - Standardized Quality Measures
  - Community Care Teams
  - Strong Collaborative Partnerships
- Integrated Health Partnership demonstration authorized in 2010 by MN Statutes, 256B.0755
- Define the **“what”** (better care, lower costs), rather then the **“how”**
- Create a common framework of **accountability** for patient’s total cost and quality of care, while ensuring flexibility

Minnesota Statutes, 256B.0755

"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."

IHP beginnings

SPRING 2011: Request for information, to gather input

- Received 40 responses

SUMMER 2011-2012: DHS developed and issued RFP based on input; Refined model with provider feedback to align with other payers

- RFP applicants were broadly representative of geographic and organizational structure

JANUARY 2013: Launched with six provider systems, serving 100,000 enrollees

2013 Legislative expansion

The commissioner shall ~~explore~~ ~~the expansion~~ expand the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration. As part of the demonstration expansion, the commissioner may procure the services of the health care delivery systems authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

2013, Chapter 81 Sec. 11. Minnesota Statutes 2012, section 256B.0755, is amended to read: Subd. 7

IHP major milestones

2011: Initial community feedback, design & RFP

2013: IHP launch & legislative expansion

2014: State Innovation Model (SIM) federal grant

2014-16: Continued provider participation and expansion

2016: Second RFI for community feedback to continue model

2017: Governor's proposal and legislative enactment of IHP population-based payment; third RFI for community feedback on Next Gen

2018: Implementation of IHP 2.0 and Encounter Alerting Service (EAS)

IHPs today

Integrated Health Partnerships improve the health of Medicaid enrollees and lower the cost of care

- Health care providers **work together** across service settings to meet patient needs.
- These providers **share in savings** they help create and in losses when goals are not met.
- They **look for innovations** to improve the health of their communities.

This builds on Minnesota's commitment to pay for value and good health outcomes instead of the number of visits or procedures people receive.

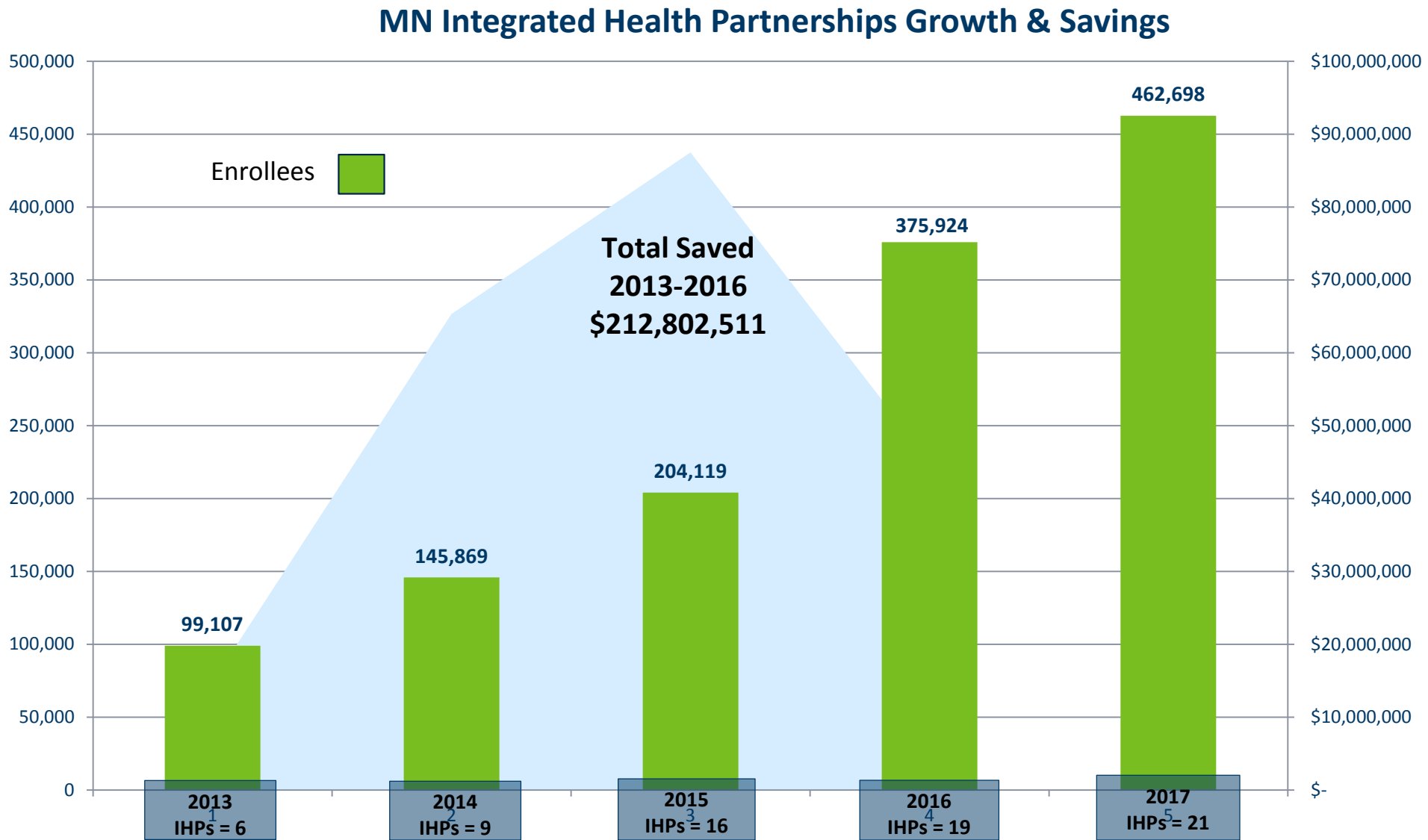
Participants, year joined
Minnesota's Integrated Health Partnership Program

Allina Health System, **2016**
Avera Health, **2018**
Bluestone Physician Services, **2015**
Children's Hospitals and Clinics of MN, **2013**
CentraCare Health System, **2013**
Courage Kenny Rehabilitation Institute, **2015**
Community Healthcare Network, **2017**
Essentia Health, **2013**
Fairview Physician Associates Network, **2017**
FQHC Urban Health Network, **2013**
Gillette Children's Specialty Healthcare, **2016**
Hennepin Healthcare System, **2014**
Integrity Health Network, **2016**
Lake Region Healthcare, **2015**
Lakewood Health System, **2015**
Mankato Clinic, **2015**
Mayo Clinic, **2014**
North Memorial Health Care, **2013**
Northern Minnesota Network, **2018**
Northwest Metro Alliance, **2013**
Perham Health, **2018**
Southern Prairie Community Care, **2014**
Tri-County Health Care, **2018**
Wilderness Health, **2015**
Winona Health, **2015**

IHPs across Minnesota

- 47% of the enrollees served are in greater Minnesota
- IHPs encompass over 500 different provider locations, and more than 10,000 individual practitioners

The successes:
Growth and savings



Other successes

+ Community collaboration contributed to original and ongoing design

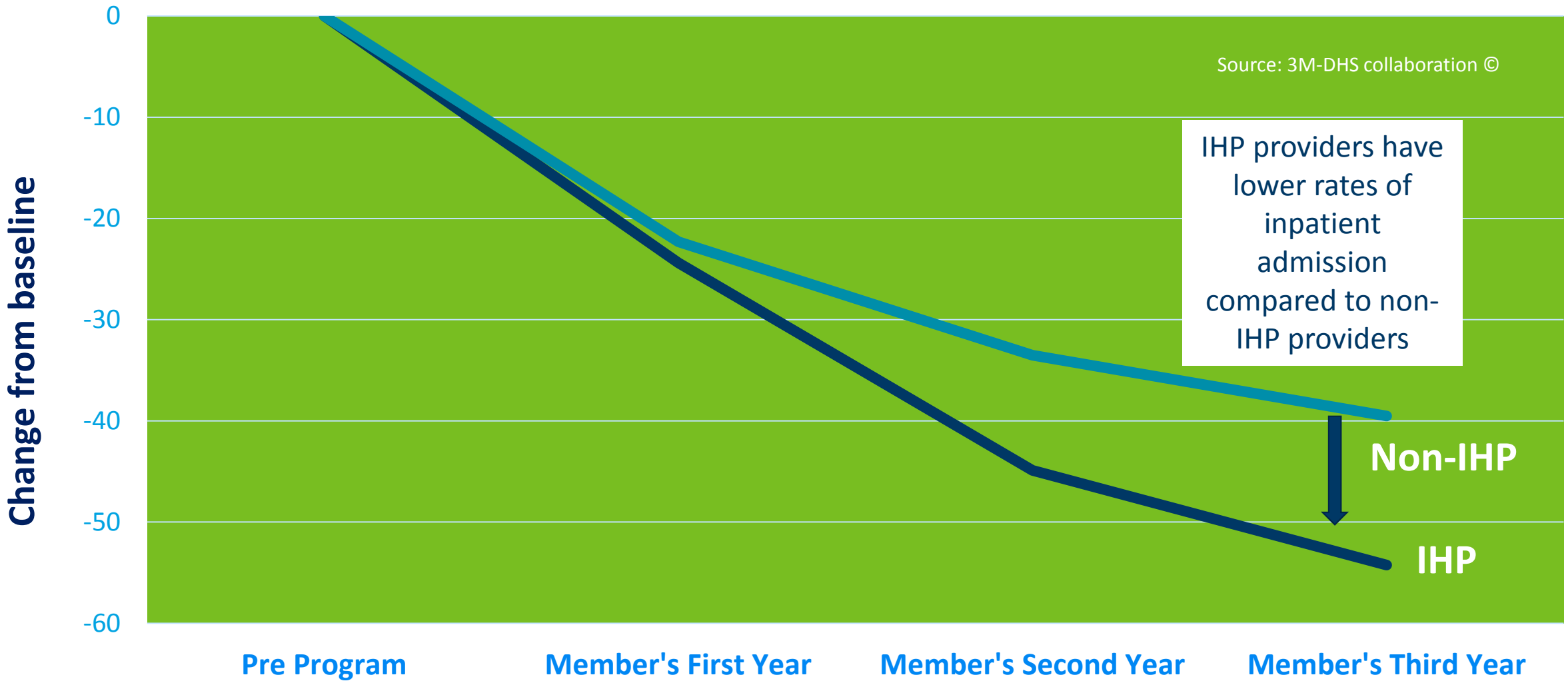
+ Steady growth in provider participation, strong retention

+ Participants maintain or improve quality of care/satisfaction

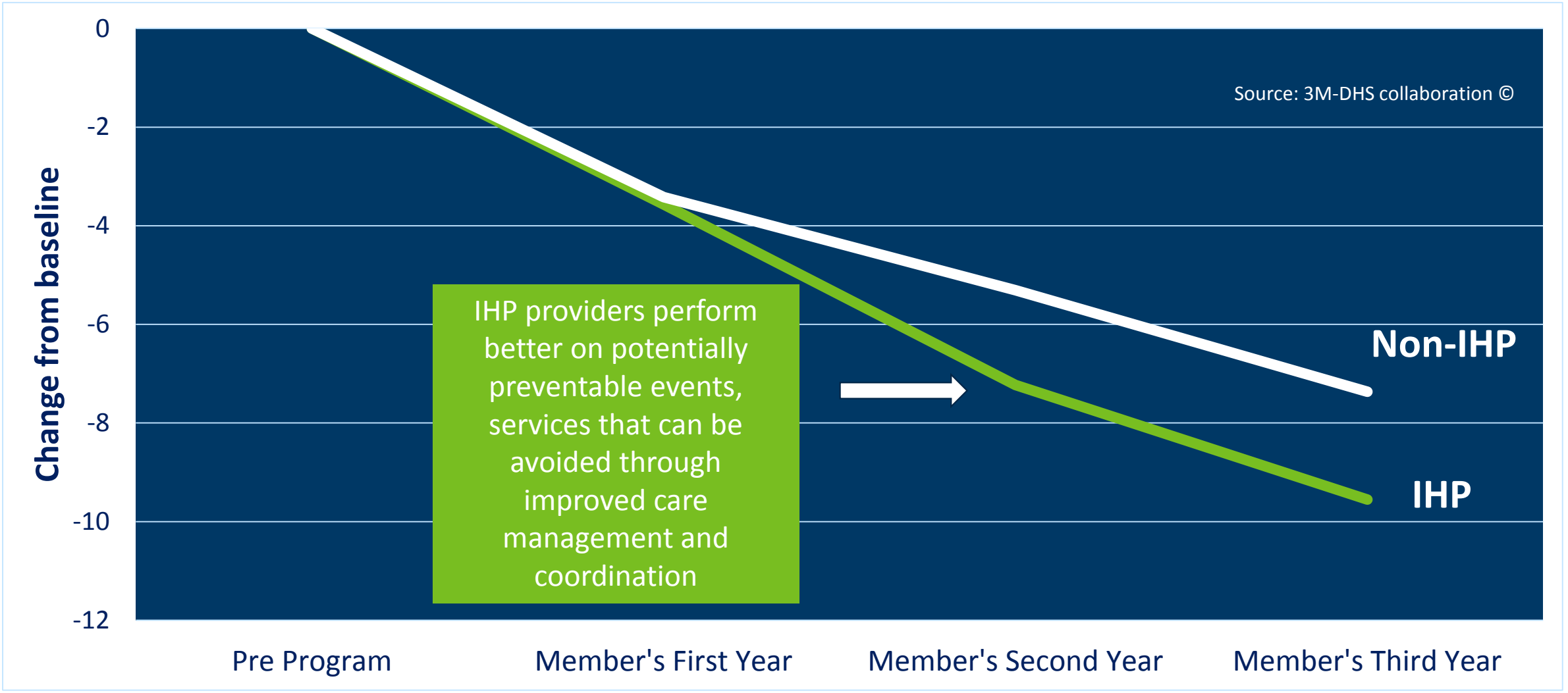
+ Participants engage in high levels of community partnerships

+ Providers have flexibility to develop the strategies that meet the needs of their patient populations

Outcomes: Right care in the right setting
Reduced inpatient admissions



Outcomes: potentially preventable events



The IHP model basics

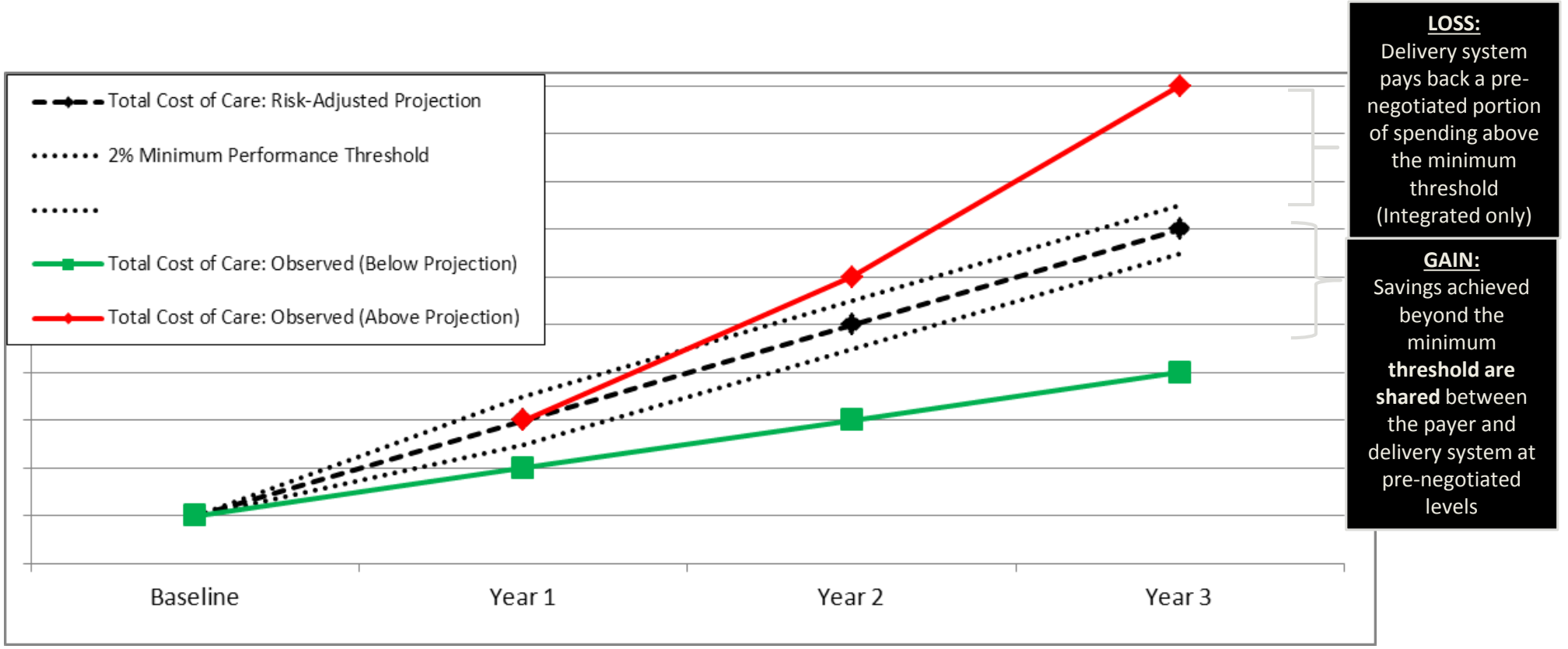
IHP shared savings are put back into the system.

The model

- **Eligible enrollees**
  - Non-dual, under 65, across both fee-for-service and all Medicaid managed care enrollees
  - Primary provider determined or “attributed” using past visits, HCH and primary care prioritized
- **Provider requirements**
  - Voluntary contracts under model options “Virtual” (shared savings only) and “Integrated” (negotiated shared savings/loss sharing) based on size and structure
  - Flexibility in governance structure and care models
- **Payment and quality model**
  - Core set of services providers are accountable for regardless of whether they deliver the care, IHP may elect to include additional services
  - Fee-for-service payments to providers continue with a settlement for gain or loss sharing payments made annually based on performance on cost & quality
  - Providers supports with data reporting and learning collaboratives

The financial incentive

Total Cost of Care financial target is measured against actual enrollee medical expenses to determine shared savings or loss if providers go above or below their target.



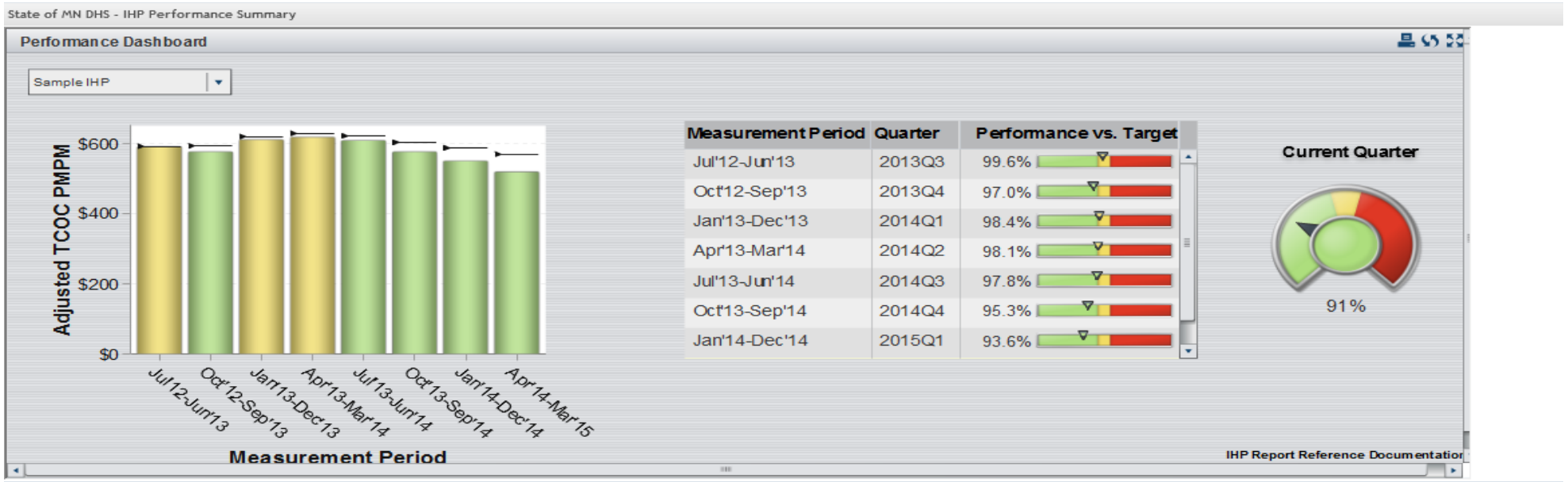
LOSS:
Delivery system pays back a pre-negotiated portion of spending above the minimum threshold (Integrated only)

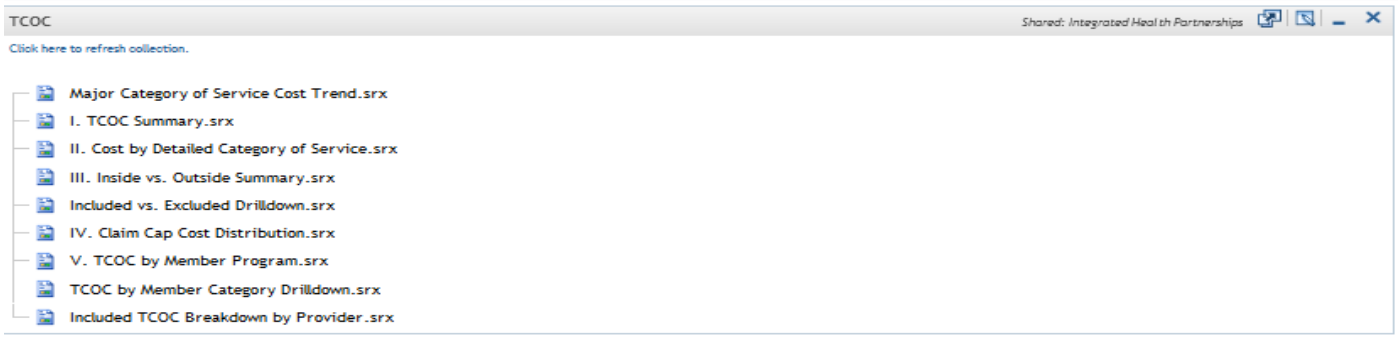
GAIN:
Savings achieved beyond the minimum **threshold are shared** between the payer and delivery system at pre-negotiated levels

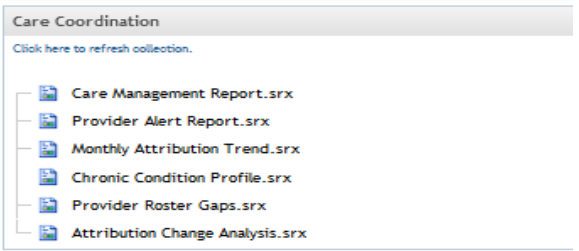
The MCO interaction

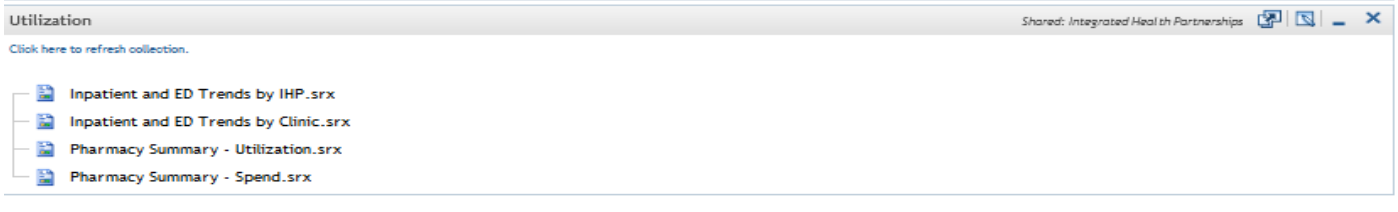
- Managed care organizations (MCOs) participate in IHPs through their contract with DHS
  - DHS provides MCOs with list of IHPs, enrollees included, cost estimates of their enrollees in IHPs, and share savings amounts due to IHPs
  - MCO is required to provide timely, accurate, and complete data to DHS
- DHS contracts directly with the IHP organizations, performs all calculations, and each MCO and DHS pay its share of the payment to each IHP (within 30 days of notice)
- MCOs still maintain their contracts with providers
- IHP financial arrangement and contract is transparent
- Some MCOs support IHPs in specific projects or with additional data or resources

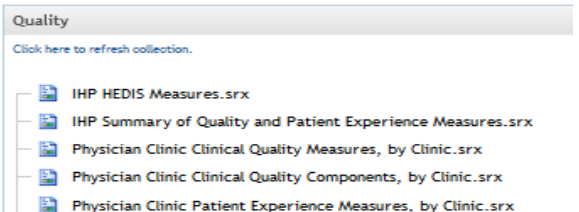
The data:
Provider Partner Portal





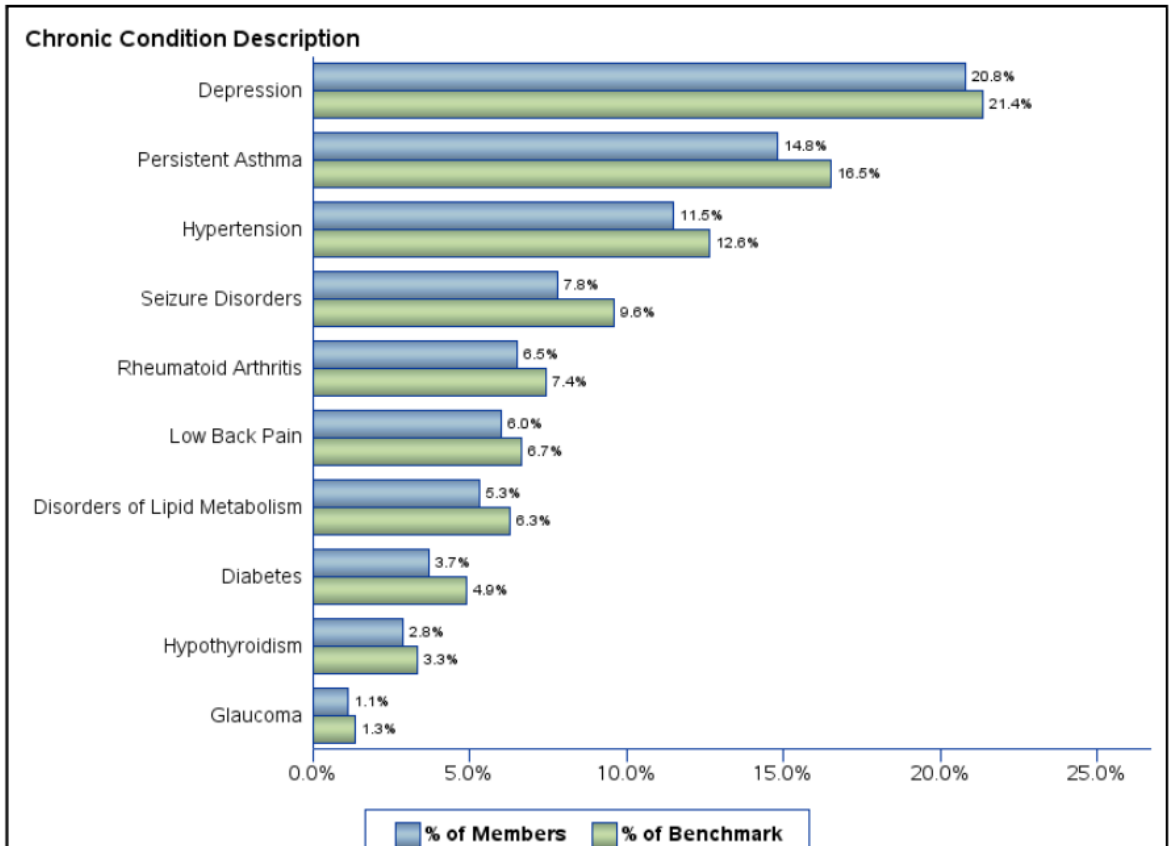






The data:
Example – Chronic Condition Profile

IHPs report a high level of satisfaction with the data, reports, peer learning and technical assistance that DHS provides. IHPs use the information to better manage the care of their population. Having the information sets available in a variety of formats and addressing many different topics allows them to use the data that works best for them.



Click text to view ALL attributed members with condition.

Chronic Condition Rank ▲	Chronic Condition Description	Members	Member Risk	% of TCOC
1	Depression	6,790	2.08	18.6%
2	Persistent Asthma	4,832	1.77	11.9%
3	Hypertension	3,740	2.33	13.2%
4	Seizure Disorders	2,539	3.05	12.2%
5	Rheumatoid Arthritis	2,115	2.62	9.2%
6	Low Back Pain	1,958	2.76	6.6%
7	Disorders of Lipid Metabolism	1,730	2.62	6.8%
8	Diabetes	1,203	2.83	5.5%
9	Hypothyroidism	926	2.28	3.1%
10	Glaucoma	362	2.43	1.1%

Rows 1 - 10

IHPs in action

IHPs are employing strategies that meet the needs of the unique populations they serve and based on community needs assessments.

Examples include:

- Utilizing community paramedics to visit patients with mental illness and substance abuse disorders.
- Partnering with county service agencies and community organizations to target wellness resources.
- Working with local schools to reach at-risk youth.

Lessons learned

- Long-term **sustainability and effectiveness** of the incentive structure
- Supporting a b**road range of providers** and provider types
- **Member attribution** that stabilizes the relationship between patient and provider
- **Enrollee engagement**
- **Clear lines of accountability**
- **Consistency of enrollee experience and continuity of care**

The IHP 2.0

IHP 2.0 – critical enhancements

Source: www.healthypeople.gov

- Enhanced focus on **social determinants of health (SDOH)** and **meaningful partnerships**
  - **Population-based payment**
  - Health equity metrics
  - "Social risk" adjustment
- **Sustainability** of innovations, interventions, and partnerships
- Multiple opportunities for a **wide variety of provider participants**

IHPs moving forward

Goals of next phase of purchasing reform

In November 2017, DHS issued request for comment on Next Generation reforms building on past feedback with the following objectives in mind:

- Focus on enrollees and outcomes
- Place value on coordination of care and services that produce better health outcomes at a reasonable cost
- Create more provider accountability for cost and quality
- Increase financial accountability over time with a proportional level of risk
- Simplify administrative and financial functions
- Reinvest in enrollees, create savings for entities and taxpayers

Summary of responses to request for comment

74 organizations or individuals submitted feedback on the following areas of work:

- **Primary care choice & network/beneficiary experience**
- **Benefit administration (e.g., Preferred Drug List [PDL], dental, NEMT)**
- **Contractual/financial arrangements**
- **Outcomes/quality measures**

Request for comment yields next steps

With the community, DHS will:

1. **Continue information gathering and community conversations** on the Next Generation IHP model through the summer of 2018.

2. **Lay the groundwork for the Next Generation IHP** approach by introducing a preferred drug list, to unify enrollee's medication experiences across coverage types and plans, in July, 2019.

3. **Procure the Families and Children contracts separately for the seven-county metro area and for the non-metro area.**

   Staging and timing of those procurements will be informed by the continuing conversation, however, the earliest a procurement will be conducted would be for contract year 2020.

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Thank you