NAHDO
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PUTTING MINNESOTA'S CLAIMS BASED DATA TO WORK

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Medicaid Payment & Delivery System Innovation: Integrated Health Partnerships

health reform
MINNESOTA
A Better State of Health

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**

Minnesota's approach to Medicaid ACO development

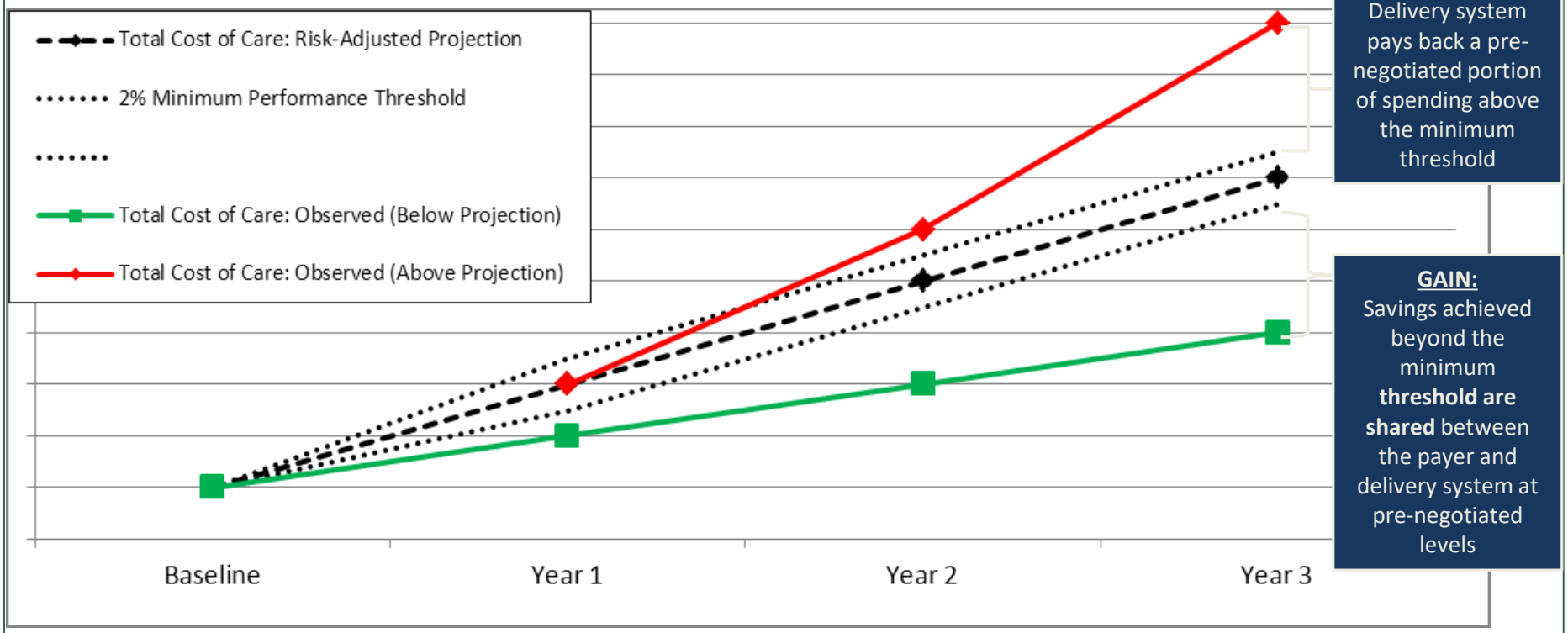
- **Integrated Health Partnership (IHP) demonstration** –authorized in 2010 by Minnesota Statutes, 256B.0755
- Builds on a long history of health reform –defines the **"what"** (better care, lower costs), rather then the **"how"**
- **Framework of accountability** includes:
  - Payment structure that drives **away from the incentive "to do more"** and **towards increasing levels of integration**
  - **"Locus of care"** provider responsible for patient populations' overall health
  - Accountability for patients' **total cost of care (TCOC)**
  - Robust and consistent **quality measurement**
- Providers voluntarily contract with DHS under two model options: **Integrated** or **Virtual**; allowing **flexibility** in governance structure, size, capacity, risk tolerance and care models to encourage innovation and local solutions.

Model Options on Common Framework

- Despite flexibility in IHP model options, all are operationalized on **common data intensive components**
  - Attribution
  - Payment/ TCOC Performance
  - Quality
  - Reporting and Feedback supports to Providers
- Data Sources:
  - Aggregated FFS and Medicaid Managed Care encounter data used to identify members receiving most of their primary care with the accountable entity
  - Claim payment and financial data used to calculate cost targets and performance; Johns Hopkins ACGv10 used for risk adjustment and care coordination indices
  - Statewide Quality Reporting and Measurement System data for quality.

Calculating 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 share distribution



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

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

Application of Quality to Payment

- 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 includes **7 clinical measures** and **2 patient experience measures** across both **clinic** and **hospital** settings
  - IHPs serving unique populations may propose alternative measures
- Each individual measure is scored based on the greater of either achievement or year-to-year improvement
  - Not always possible to calculate improvement when measure changes from previous year

Example Calculation (Integrated)

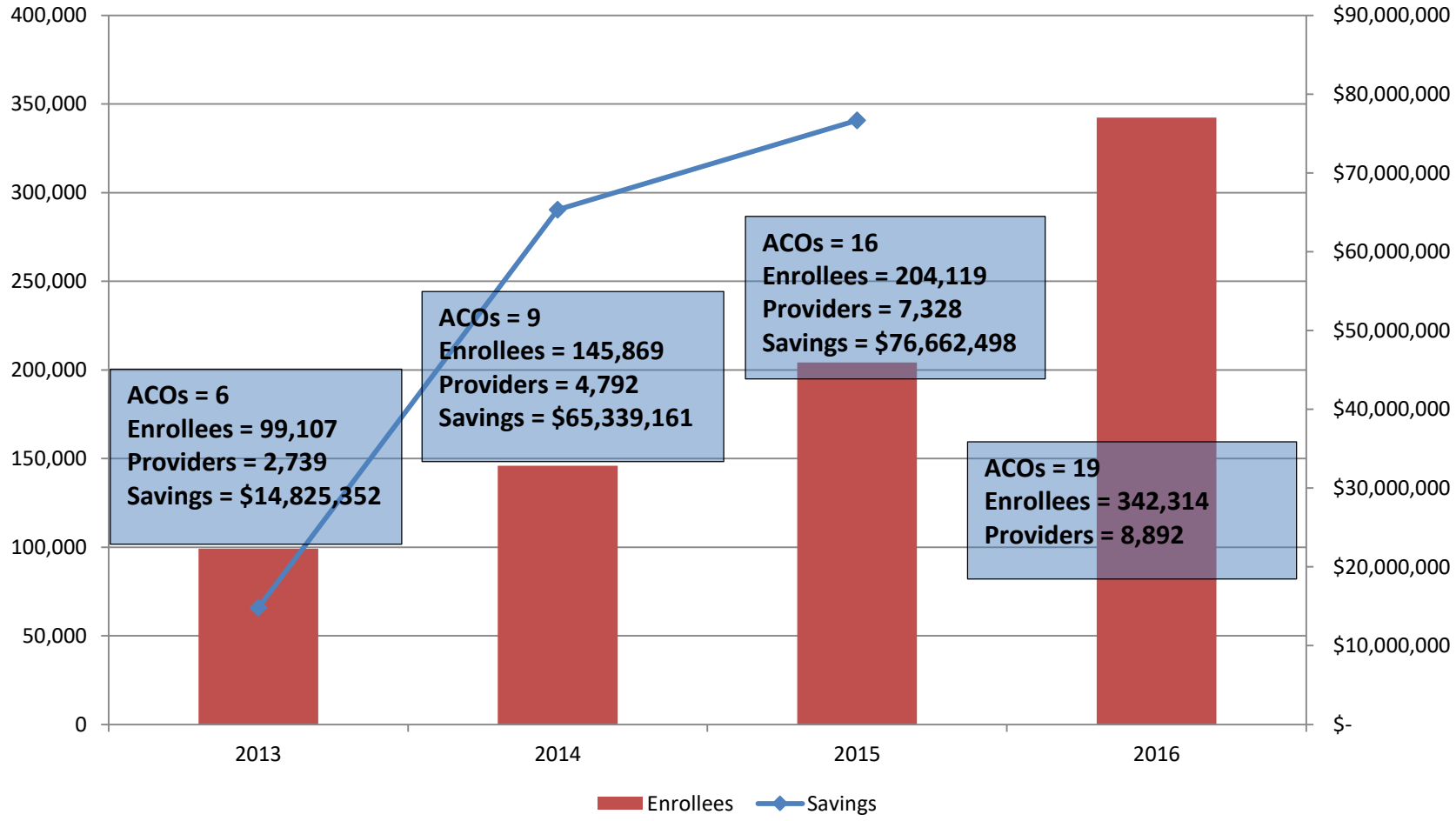
Category	Points Earned	Points Possible	Weight (%)	Percentage of Possible Points
Optimal Diabetes Care	1.85	2		
Optimal Vascular Care	2.00	2		
Depression Remission	1.10	2		
Asthma – Children / Adolescent	1.40	2		
Asthma - Adults	1.55	2		
Clinical (clinic)	**7.90**	**10**	**45**	**79.0%**
Heart Failure	2.00	2		
Pneumonia	1.85	2		
Home Management Plan for Asthma	1.40	2		
Clinical (hospital)	**5.25**	**6**	**30**	**87.5%**
Clinical (Total)	13.15	16		
Patient Experience (clinic)	**1.85**	**2**	**15**	**92.5%**
Patient Experience (hospital)	**2.00**	**2**	**10**	**100.0%**
Patient Experience (Total)	3.85	4		
Total	17.00	20		
Overall Quality Score				**85.7%**

- Example: Year 3 – 50% Impact on shared savings
- Total shared savings = $2,000; HCDS' total potential shared savings = $1,000
- HCDS' total shared savings impacted by quality results = $500
- HCDS' total shared savings impacted by quality results = $500 * 85.7% = $428.50
- HCDS' total shared savings earned = $500 + $428.50 = $928.50

How do we help the IHPs succeed? Reporting and Data Feedback

- **Actionable baseline reports** via web-based portal (sample and detail on next slides)
- SFTP distribution of Claim and Pharmacy Utilization files to allow IHPs to **integrate** with clinical repositories and other population health tools
- Monthly Recipient Demographic file, includes indicators of homelessness and other risk and care coordination markers
- **Quarterly Data User Groups** – IHPs share best practices and provide feedback on reports and data use

MN Integrated Health Partnerships Extension and Savings



How are the IHPs doing?
Cost goal exceeded

- Cumulative saved across IHPs compared to cost targets estimated at $156.8 million
  - 2013 - $14.8m
  - 2014 – $65.3m
  - 2015 interim - $76.7m

- IHPs build on prior success
  - In 2013, all 6 beat cost targets and 5 received shared savings payments ($6 million total ranging from $570k to $2.4 million)
  - In 2014, all 9 providers received shared savings settlements ($23.3 million in total ranging from $388k to $4.7million)
  - In 2015, 12 of 15 beat targets and 10 received interim settlements will be made final in late Spring 2017)

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
- Can be challenging to identify specific interventions that drive results.
- Risk adjustment methods need further development and enhancement to effectively capture medically and socially complex populations served
- Desire to make continued improvements in **patient attribution/assignment** to capture those not accessing primary care, interest in prospective or enrollment models

DHS Health Care Administration

OTHER USES OF HEALTH CLAIMS DATA

HEDIS Measures Report: Measure Categories

Effectiveness of Care	**Access/Availability of Care**
1. Childhood Immunization Status 2. Breast Cancer Screening 3. Colorectal Cancer Screening 4. Medication Management for Asthmatics 5. Mental Health Hospitalization Follow-up	1. Adults' Access to Preventative/Ambulatory Services 2. Annual Dental Visit 3. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Utilization & Risk Adjusted Utilization	**Adapted for Financial Incentives/Withholds**
1. Plan All-cause Readmissions 2. Emergency Dept. Utilization 3. Inpatient Hospital Utilization	1. Child and Teen Check-ups Referral 2. Well-child Visits in the First 15 Months of Life 3. Emergency Dept. Utilization Rate 4. Hospital Admission Rate 5. 30 Day Readmission Rate 6. Annual Dental Visit 7. Initial Health Risk Screening/Assessment

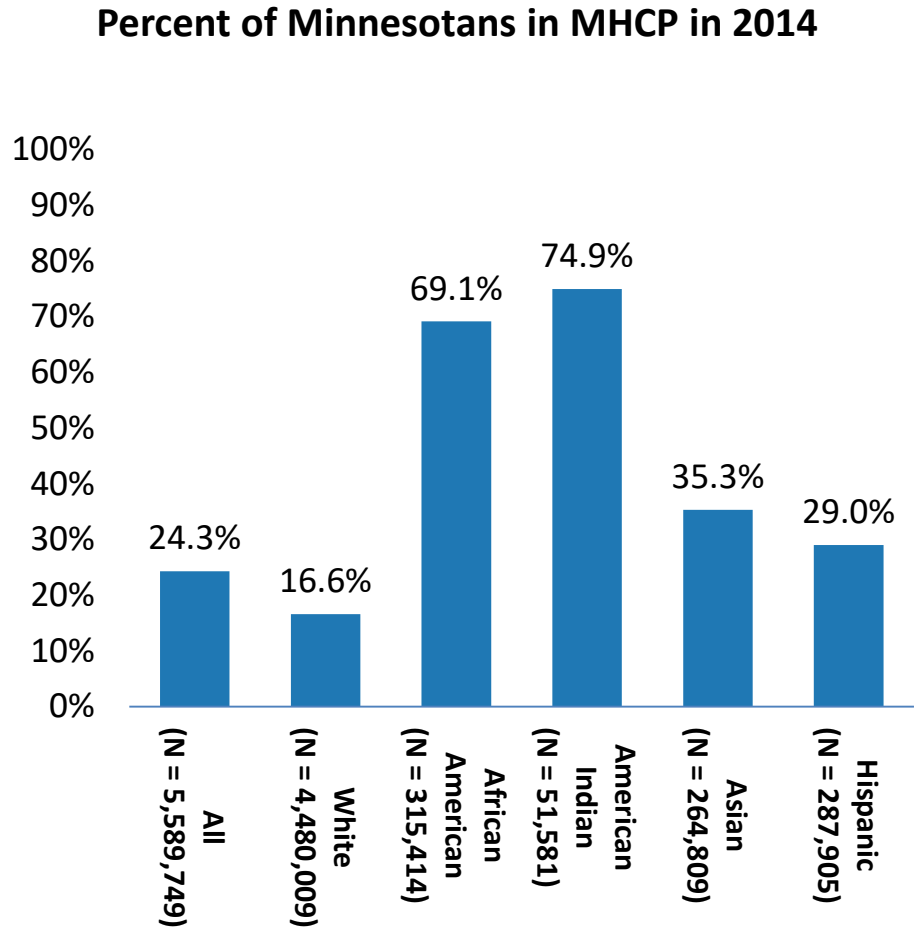
HEDIS Measures: Outcomes

- Serious Deficiencies Can Be Directly Addressed
  - Racial/Ethnic, Gender, Age-related Disparities
  - Over-Utilization of High-Cost Services
  - Assessment of Responses to Long-Standing and Emerging Public Health Issues

- Why Calculate Our Own Rates?
  - Verify Findings of MCO's
  - Ensure Similar Methodologies are Used Across Entities
  - Increased Confidence in Data Capabilities

Racial Composition of Minnesota and Minnesota's Health Care Programs

- Findings:
  - Approximately ¼ of all Minnesotans participate in MCHP
  - Higher ratios of minority race and ethnic populations are in MHCP
- Areas for improvement:
  - Race data not complete in the claims data warehouse
  - Race is self-reported on applications for MHCP, therefore the reliability in question
  - Race data from ACS were extrapolated from July 2014 to the entire year
- Conclusion
  - MHCP can have substantial impact on health care received by minority groups because larger proportions receiving some of their care via MHCP



Social Determinants of Health and Health Care Utilization

- **Objective**: Identify social risk factors which are associated with higher costs and poor outcomes
- **Population**: MN Health Care beneficiaries ages 0 – 64
- **Data**: Benefits info, eligibility, administrative FFS and MCO claims, state and provider payments, Quality performance
- **Objective**: Compensate providers based on risk factors and outcomes of beneficiaries served
- **Challenges**: Massive volume of data, obtaining eligibility status from three eligibility systems, quality measures may not apply to some beneficiaries

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THANK YOU