health reform
MINNESOTA
A Better State of Health

Executive Summary
The Minnesota Accountable Health Model

Minnesota submission to
The Center for Medicare and Medicaid Innovation-State Innovation Models Initiative
September 2012

Background

In July 2012, The Center for Medicare and Medicaid Innovation released a competitive funding opportunity for states test innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. The goal is to create multi-payer models with a broad mission to raise community health status and reduce long term health risks for beneficiaries of Medicare, Medicaid, and CHIP.

States were eligible to submit a statewide proposal for either one year of support for State Innovation Model Design or three and a half years for a State Innovation Model Testing award. Based on stakeholder feedback, Minnesota submitted a Model Testing proposal for the *Minnesota Accountable Health Model*. The proposal was submitted on September 24, 2012 and the Innovation Center expects to announce awards in December 2012.

Problem Statement

Minnesota has made significant progress toward the Triple Aim of improved health, improved care, and lower costs through dramatic transformations in health care delivery, led by home grown innovations among our integrated health care systems and payer partners.

However, millions of Minnesotans continue to experience fragmented, uncoordinated care. This fragmentation is even more pronounced when individuals have complex health issues and need multiple types of care, such as mental health, substance abuse and long term supports and services. The lack of coordination between services results in poorer health and higher costs for families and the state. While these challenges exist statewide, providers that are small, independent, serve as the health care safety net, or are in rural areas face unique barriers to improved care coordination across systems.

Input and Collaboration on the Minnesota Submission

The Department of Human Services and the Department of Health held three meetings with stakeholders during June through September to discuss and prepare the Minnesota submission. Approximately 150 representatives from across the continuum of health care, mental health, social services, and long term supports and services attended these meetings. Overall, participants expressed strong support for a Model Testing submission that would build on accountable care organizations and health care homes underway in Minnesota, and include a focus on complex patients, mental health and community engagement.

The proposal was a joint submission from the Department of Human Services and the Department of Health, with support from the office of Governor Mark Dayton. Over 100 Minnesota organizations representing health care providers, public health, counties, tribes, social services and health plans provided letters of support. These included the Minnesota Medical Association, the American Academy of Pediatrics (Minnesota Chapter), the Minnesota Council of Health Plans, the Minnesota Health Care Safety Net Coalition, and National Alliance on Mental Illness-Minnesota. The complete list of letters of support and other application materials are available online: http://mn.gov/health-reform/health-reform-in-Minnesota/index.jsp

Model Overview

To address the current fragmentation and to integrate services for the whole person across the continuum of care (health care, mental health, long term care and other services), the *Minnesota Accountable Health Model (Minnesota Model)* offers a comprehensive, statewide initiative to close the current gaps in health information technology, secure exchange health information, quality improvement infrastructure, and workforce capacity needed to provide team-based coordinated care.

If funded, the *Minnesota Accountable Health Model* will expand Minnesota's current Medicaid Accountable Care Organizations (ACOs) demonstrations, in collaboration and alignment with similar models in Medicare and among commercial payers. The *Minnesota Model* focuses on improving health and lowering costs for people with complex health needs while moving the majority of health care in Minnesota to shared savings/shared risk payment arrangements. These ACOs will hold providers and payers accountable for cost and quality of services, and health overall.

While expanding Medicaid ACO models, Minnesota will also develop integrated community service delivery models that bring together health care, behavioral health, long term care, and community prevention services to provide care centered on the needs of individuals and families. The goals of the *Minnesota Accountable Health Model* are to:

- Transform care delivery so that every patient receives the option of team-based, patient-centered care, coordinated across behavioral health, long term care, and other services;
- Accelerate adoption of ACO models in Medicaid that are aligned with other payers
- Ensure that the majority of providers are able to securely exchange data (after receiving patients' consent) among care partners, within and outside of the health care system;
- Create Accountable Communities for Health across the state, in which integrated networks of providers and community organizations are accountable for improved population health.

Implementation of the Model will be led by the Commissioner of Human Services and the Commissioner of Health in consultation with a Community Advisory Committee and a Multi-payer Alignment Group (including commercial payers and Medicare). By 2016, the Model will directly impact 190,000 Medicaid enrollees in Medicaid ACOs, while also benefiting Minnesotans statewide through investments in infrastructure, care integration and practice transformation among health care and other providers.

Budget Overview

If funded, the grant award would fund a six-month implementation period, followed a three-year testing period with a proposed budget of $56,637,000. Of that total, roughly $23 million are investments in health information technology, secure exchange of health information and data analytics; $2.5 million to support quality and performance measurement; $6.3 million to support practices to improve care coordination; and $10 million to support up to 15 Accountable Communities for Health to develop models that integrate care across the continuum and share risk/savings in a community. The additional funds would support advisory groups, evaluation and project management. Providers in smaller practices, rural areas and who serve the health care safety net would be prioritized across these activities.

Savings from the Minnesota Model are projected at $111.1 million over the three-year period--with $90.3 million in Medicaid savings, $13.3 million in savings to private payers and $7.5 million in Medicare savings

<u>Budget Background: ACO Implementation, Health IT, Data Analytics, Provider Transformation</u>
The availability of actionable and complete feedback is critical to Medicaid ACO participants' ability to manage quality and total cost of care. DHS would partner to build and operate data warehouse capability to integrate claims and encounter data from DHS, as well as data directly from managed care organizations and Medicaid ACO participating provider entities. This would include:

- Open architecture to interface with other secure systems such as inpatient census and emergency department visit data, transferred using secure protocols from collaborating health plans and/or hospitals to help illuminate who most needs support
- Create analytics and reporting incorporating predictive modeling, member risk information, performance monitoring/benchmarking, and evaluating utilization variances.
- Provide customized and standard reports with technical assistance for providers to interpret reports and identify opportunities for improvement
- Conduct an iterative needs assessment over the demonstration years as the participating entities make continuous improvements and, along with DHS, learn what information is needed for monitoring and identifying opportunities for reductions in total cost of care.

Financial and technical assistance would also be available for providers to transform service delivery:

- Become certified Health Care Homes;
- Adopt electronic health records or other health information technology (including $2.5 million in grants/year for HIT adoption/data exchange);
- Engage in secure, standards-based exchange of clinical information between providers and with the State;
- Integrate new professions into their care delivery teams/systems (including start-up grants for early adopters of these models);
- Make use of learning collaboratives and practice facilitators to redesign systems and care delivery to support care coordination and integration of care across the continuum.

Budget Background: ACO Measurement, Quality Measurement & Data Collection Budget Areas
The measurement budget is focused on strengthening and expanding the current measurement infrastructure to support new shared/risk shared savings models, including complex populations. Major measurement budget components include:

- Oversampling the existing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to have a sufficient denominator to measure patient satisfaction by Medicaid ACO sites;
- Contract with Minnesota Community Measurement (MNCM) to expand its annual analysis to include grouping clinic level data by ACO entity. MNCM collects 13 current measures, with additional measures at various stages of development, including data by race/ethnicity;
- Development of new quality measures (including for medically complex patients, pediatric populations, and care coordination), drawing on existing standards and metrics;
- Actuarial and consulting support for continued development and execution of shared savings/risk payments models such as testing and improvements to the current Medicaid ACO attribution methodology, risk adjustment, payment model (including development of prospective payment), cost trend, and data feedback report development.

Budget Background: Accountable Communities for Health Budget Areas
The *Minnesota Model* would support development of up to 15 ACHs that build on Minnesota's pilot Community Care Teams to improve integration of health care with behavioral health, long term supports and services and social services, and to strengthen community engagement in ACOs.

Funds would focus on:

- Support for providers to integrate services through Community Care Teams, including support for community-identified prevention priorities;
- Support for citizen/community partner participation on ACH Community Leadership teams, to prevent barriers to significant consumer and community involvement;
- Leadership team to develop a sustainability plan, and rapid-cycle evaluation of the model.

Overview of major budget components

	Yr 1 (6 mos)		Year 2		Year 3		Year 4		Total
	$000s	FTE	$000s	FTE	$000s	FTE	$000s	FTE	$000s
Personnel									
ACO Implementation & Data Analytics	137	5.0	394	5.0	394	5.0	394	5.0	$ 1,319
Secure Provider Data Exchange	117	6.0	391	6.0	391	6.0	391	6.0	$ 1,290
ACO Provider Transformation	139	5.5	373	5.5	373	5.5	373	5.5	$ 1,258
ACO Measurement	62	3.0	207	3.0	207	3.0	207	3.0	$ 683
Accountable Communities for Health	126	4.5	291	4.5	291	4.5	291	4.5	$ 999
Project Mgmt, Advisory Group, Evaluation	105	3.0	238	3.0	238	3.0	238	3.0	$ 819
Total Personnel	$ 686	27.0	$ 1,894	27.0	$ 1,894	27.0	$ 1,894	27.0	$ 6,368
Fringe	218		594		594		594		$ 2,000
Contractors, Vendors, Data Collection									
ACO Implementation & Data Analytics	500		3,850		3,350		2,850		$ 10,550
Secure Provider Data Exchange	300		3,650		3,100		2,850		$ 9,900
ACO Provider Transformation	-		1,940		1,680		1,480		$ 5,100
ACO Measurement	-		600		750		550		$ 1,900
Accountable Communities for Health	30		1,265		4,685		3,110		$ 9,090
Project Mgmt, Advisory Groups, Evaluation	-		1,733		2,449		2,852		$ 7,034
Total Contractors, Vendor, Data Collection	$ 830		$ 13,038		$ 16,014		$ 13,692		$ 43,574
Equipment	193		157		149		149		$ 648
Travel, training, workshops	12		96		96		96		$ 300
Supplies and miscellaneous	30		60		60		60		$ 210
Other	-		-		-		-		$ -
Indirect	336		1,102		1,101		998		$ 3,537
Total	$ 2,305		$ 16,941		$ 19,908		$ 17,483		$ 56,637