Update on Integrated Care System Partnerships (ICSPs)

Stakeholder’s Meeting for Seniors and People with Disabilities
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Integrated Care System Partnerships

- Builds from current MCO/Provider “Care System” contracting arrangements (current providers may convert to ICSPs)
- Combined Medicare and Medicaid financing provides incentives for provider level payment and delivery reforms stimulating new subcontracting arrangements and affiliations across services.
- New CMS demonstration supports inclusion of Medicare services for seniors in ICSPs through contracts with Medicare Special Needs Plans for seniors with dual eligibility in MSHO
- Seniors: Encourages involvement of long term care providers under shared pooled incentives or payment reform models
- People with Disabilities: Encourages coordination of physical and behavioral health for people with disabilities in SNBC
- All models to incent improved health outcomes and choice of care setting
Integrated Care System Partnerships

• Proposals are subject to State contract requirements for care coordination, quality metrics, financial performance measurement and reporting

• Tied to a range of quality and financial performance metrics:
  – Clinical workgroups developed quality measure options
  – Measures will differ between systems based on many factors: size, population served, setting of care, geographic area, etc.
  – ICSPs can propose alternative measures

• Financial metrics proposed according to broad State parameters

• SNP/MCO/Provider implementation of new ICSP arrangements no later than January 2014.

• 30 ICSP proposals in total were received, reviewed and accepted:
  ➢ 60% Seniors
  ➢ 26% SNBC
  ➢ 13% Both Seniors and SNBC
Blue Plus ICSPs

Partners:
   1) Essentia Health (Seniors)
   2) Services of Minnesota (GSM) (Seniors)

ICSP Measures:
   1) Plan all cause readmissions using claims data
   2) Use of high risk medications in the elderly using pharmacy data

ICSP Expectations:
   1) Improve patient experience of care
   2) Improve health of populations
   3) Reduce the per capita cost of health care
HealthPartners ICSPs

Partners
1) HealthPartners Medical Group with 9 LTC Facilities (Seniors)
2) Park Nicollet Clinics and 3 LTC Facilities (Seniors)
3) Six contracted interpreter agencies (Seniors)

ICSP Measures:
1) Facility acquired pressure ulcers
2) Falls with injury
3) Advanced Care Planning
4) Pre and Post training interpreter understanding

Expectations:
1) Improve quality of care reducing facility acquired pressure ulcers
2) Reduce falls with injury
3) Enhance understanding for end of life decision making
4) Better experience for the member
Itasca Medical Care ICSPs

Partners
1) IMCare Primary Care (Seniors)
2) IMCare Institutional Facilities (Seniors)

ICSP Measures:
1) Preventive services
2) Care Coordination for optimal outcomes
3) Medication reconciliation per published HEDIS specifications

Expectations:
1) Improve healthcare
2) Cost savings through care coordination across all facets with 100% of savings to risk providers with incentives aligned
3) Improve healthcare outcomes via medication reconciliation
Medica ICSPs

Partners

1) Presbyterian Homes (Independent and N.H.) *(Seniors)*
2) Geriatric Services of Minnesota (GSM) *(Seniors)*
3) Essentia *(Seniors)*
4) Care Choice *(Seniors)*
5) Fairview Partners (FVP) *(Seniors)*
6) Mental Health Resources *(SNBC)*
7) Courage Center *(SNBC)*
8) Guild *(SNBC)*
9) Touchstone *(SNBC)*
10) Spectrum *(SNBC)*
Medica ICSPs

Measures:
1) Flu shots
2) Physician’s Order for Life Sustaining Treatment (POLST)
3) Inpatient utilization
4) Plan all cause readmissions (PCR)
5) High risk medications
6) Medication reconciliation
7) Follow-up hospitalization for mental illness (MI)
8) Behavior and Physical Health integration evidence
9) Mental and behavioral health integration evidence
10) Thirty day readmission to hospital rate
11) Fall prevention
12) Patient Activation Measurement (PAM) – measure patient engagement

Expectations:
1) Cost savings via a reduction in hospital readmissions, Physician’s Order for Life Sustaining Medical Treatment (POLST) completed, reduction in falls, medication reconciliation, depression screenings
2) Improved quality of life for the member with a reduction in all cause readmissions and high risk medications
Metropolitan Health Plan ICSPs

Partners
1) Care Choice  (Seniors)
2) Catholic Charities, Keystone Community and Meridian Services (Seniors)
3) Community University Health Care Center (CUHCC) (SNBC)
4) Touchstone Mental Health (SNBC)

ICSP Measures:
1) Inpatient utilization (HEDIS: Inpatient, Medicine and Surgery)
2) Emergency Department utilization (HEDIS: Ambulatory care / Emergency Dept.)

Expectations:
1) Reduce potentially avoidable hospital inpatient admissions
2) Reduce emergency department visits
3) Appropriate utilization of services
4) Cost savings creates a performance pool to be distributed to partner organizations based on meeting or exceeding performance metrics
PrimeWest Health ICSPs

Partners
1) Affiliated Community Medical Centers (ACMC), Alexandria Clinic and Douglas County Hospital (Seniors)
2) Knute Nelson (LTC) (Seniors)
3) Alexandria Clinic, Douglas County Hospital, and Red Lake Rural Co-Integrated Care (Sanford Health of Thief River Falls) (SNBC)

ICSP Measures:
1) Ambulatory Care Sensitive Conditions (ACSCs)
2) High risk medications
3) Medication management reconciliation post discharge
4) Antidepressant medication management for 18 years plus
5) Follow-up care for children with attention deficit hyperactivity disorder (ADHD)

Expectations:
1) Optimal clinical outcomes
2) Better functional status/outcomes
3) Improve patient and provider satisfaction
4) Reduce inappropriate utilization of health care resources and services
5) Fewer preventable illnesses and hospitalizations
6) Fewer unnecessary health care costs
South Country Health Alliance (SCHA)

Partners
1) First Light Health System, Allina SeniorCare Transitions and St. Clare Living Community (Seniors)
2) Mayo Clinic Health System Provider Network (MCHS), MMSI and SCHA (Seniors/SNBC)

ICSP Measures:
1) Reduce ER visits
2) Reduce Hospital re-admissions
3) Completion of Annual Reviews of Advanced Care Plan
4) Primary Care Team (PCT) contacted prior to emergency room (ER) or inpatient admission
5) PCT contacted prior to ER or inpatient admission
6) Use of antipsychotics for people with Dementia
7) Completion and Annual Review of Advanced Care Plan with PCT
8) Preventive Screenings
South Country Health Alliance (SCHA)

Expectations:
1) Improved care outcomes
2) Overall cost savings
3) Enhanced member satisfaction
4) Less disruption to the member by providing as many services as possible on-site
5) Enhanced communication with Nurse Practitioner (NP) on-site and improved care planning
6) Cost savings will be achieved through more appropriate ER and acute care utilization, substitution of skilled nursing and intensive service days provided in the nursing home
UCare ICSPs

Partners
1) Fairview Partners (Seniors)
2) Geriatric Services (GSM) (Seniors)
3) Bluestone Medical Team (Seniors/SNBC)
4) Care Choice (Seniors/SNBC)
5) Mental Health Resources (MHR) (Seniors/SNBC)

ICSP Measures:
1) Annual monitoring of patients on persistent meds
2) POLST- direct patient contact regarding life sustaining treatment
3) Plan all - cause readmissions (PCR)
4) Inpatient utilization for general hospital/acute care (IPU)
5) Advanced care planning
6) Follow-up after hospitalization for mental illness
7) Falls with fracture
8) Re-admissions
9) Anti-depressant medication management
UCare ICSPs

Expectations:

1) Increase percentage of patients receiving monitoring on persistent medications
2) Increase percentage of patients receiving advanced care planning / POLST
3) Decrease the percentage of patients being re-admitted
4) Decrease inpatient utilization for general hospital/acute care
5) Increase follow-up after hospitalization for mental illness
6) Reduce falls with fracture
7) Reduce re-admissions
8) Increase the percentage of patients that remain on anti-depressant medications for a minimum of 84 days initially then 180 days
Top Five Proposed ICSP Measures (Seniors)

1) Plan All-Cause Readmissions (PCR)
   - The number of acute inpatient stays during the measurement years that were followed by an acute readmission for any diagnosis within 30 days and the predicated probability of an acute readmission

2) Inpatient Utilization- General Hospital/Acute Care
   - Summarizes utilization of acute inpatient care and services in the following categories: Total inpatient, Medicine, Surgery, and may also be disease specific rather than general hospitalizations

3) Advanced Care Planning/ POLST
   - Percentage of members age 65 or greater who have evidence (i.e.- documentation) of advanced care planning in their medical record at their health care home clinic or nursing facility across a 12 month period

4) Use of High Risk Medications in the Elderly (DAE)
   - Percentage of Medicare members 66 years of age and older who received at least one or two high risk medications

5) Medication Reconciliation Post Discharge (MRP)
   - Percentage of discharges for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge
Top Three Proposed ICSP Measures (SNBC)

1) Plan All-Cause Readmissions (PCR)
   - The number of acute inpatient stays during the measurement years that were followed by an acute readmission for any diagnosis within 30 days and the predicated probability of an acute readmission

2) Anti-Depressant Medication Management (AMM)
   - Percentage of participants 18 years and older with a diagnosis of major depression; newly treated with anti-depressant medication and remained on antidepressant medication treatment

3) Medication Reconciliation Post Discharge (MRP)
   - Percentage of discharges for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge
Summing It Up

• MSHO/SNBC aligning with new delivery systems through formation of new ICSPs and HCDS
• ICSPs expected to further integrate primary care, behavioral health and LTSS care coordination mechanisms
• ICSPs will link clinical and financial performance
• Dual demo supports Medicare inclusion in ICSPs
• 2014 contracts expected to increase ICSPs
• Measurement will be challenging and will have to evolve over time!
Joint CMS/State Memorandum of Understanding (MOU) for Medicare and Medicaid Managed Care

- Demo under Medicare Advantage Special Needs Plan (SNP) platform and payment structures
  - Includes Medicare, Part D, current Medicaid State plan and LTSS (seniors) starting 2013
  - SNBC TBD for 2014 Phase 2
  - MOU to outline State/CMS oversight roles
  - CMS acknowledgement of State payment and delivery reform goals
  - "Rules for duals" supports features needed to continue and improve integrated operational features including quality and outcomes measurement and integrated benefit determinations, provider billing and protection from premiums for enrollees

Acronyms
- CD = Chemical Dependency
- CMS = Centers for Medicare and Medicaid
- FFS = fee for service
- HCH = Health Care Home
- HH = Health Home
- ICSP = Integrated Care System Partnership
- LTSS = Long Term Services and Supports
- MMICO = Medicare Medicaid Integrated Care Organization
- MSC+ = Minnesota SeniorCare Plus
- MSHO = Minnesota Senior Health Options
- NF = Nursing Facility
- PAC = Post Acute Care
- SNBC = Special Needs BasicCare
- SNP = Medicare Advantage Special Needs Plan
- SMI = Serious Mental Illness
- TCOC = Total Cost of Care

Virtual Care Systems
- Communication Tools
  - Model 1

Care Coordination
- MMICO/Counties/Trades/Community Organizations

Chemical & Mental Health

Acute Care

Market Incentives and Stimulation

Model 1: SNPC DEMO PLAN S
Special Needs Plan Medicare and Medicaid Integrated Care Organizations
Contract Requirements and Risk

Model 2: Integrated Care System Partnerships (ICSP)
- DHS establishes criteria for model options for ICSPs including:
  - Primary care/payment reforms
  - Integrated care delivery
  - TCOC accountability and options for risk/gain sharing arrangements
  - Opportunities for PAC/NF/LTSS/MH/CD providers
  - HCH Certification/Transition to HCH
  - Enrollee choice of ICSP
  - Incentives to serve people across all settings
  - Standardized outcome measures
- New ICSPs
- DHS Issues RFPs to stimulate additional ICSPs
- Provider/MMICO Partnership required for response
- DHS sets payment and risk/gain options and parameters

Existing Care Systems
- DHS evaluates current care systems arrangements, those meeting or exceeding criteria would be considered ICSPs
- Transition to HCH if not already HCH
- Standardized outcome measures

Model 3: Specialized ICSPs
Mental, Chemical and Physical Health
- DHS establishes criteria for integrated chemical, mental and physical health care system models for people with SMI enrolled in SNBC under the demonstration
- DHS issues RFP
- Requires partnership between county, MMICO, primary care, chemical and mental health providers
- Could also include non-dual SNBC members
- Additional details TBD with Chemical and Mental Health and Continuing Care
- Exploring Health Homes and/or HCH as part of model
- Standardized outcome measures
- Dependent on viable Medicare financing under demo for dual eligibles with disabilities

MMICO+:
- Medicare coordinates with Original Medicare

MSC+:
Medicaid coordinates with Original Medicare

SNPC DEMO PLAN S
Special Needs Plan Medicare and Medicaid Integrated Care Organizations
Contract Requirements and Risk

虚拟护理系统
- 通信工具
  - 模型1

护理协调
- MMICO/县/种族/社区组织

化学和精神健康

急症

市场激励和刺激

模型1：SNPC DEMO PLAN S
特殊需求计划/医疗保险和Medicaid集成护理组织
合同要求和风险

模型2：集成护理系统合作伙伴关系（ICSP）
- DHS建立标准，为ICSP中的模型选项制定标准，包括：
  - 主要护理/支付改革
  - 集成护理交付
  - TCOC问责制和为风险/收益共享安排制定选项
  - 机会为PAC/NF/LTSS/MH/CD提供者
  - HCH认证/过渡到HCH
  - 受益人选择的ICSP
  - 为所有设置提供激励，以在所有设置中提供服务
  - 标准化的结果指标
- 新的ICSPs
- DHS发布RFPs来刺激额外的ICSPs
- 提供者/MMICO合作伙伴关系需要响应
- DHS设置支付和风险/收益选项和参数

现有护理系统
- DHS评估当前护理系统安排，达到或超过标准的护理系统将被视为ICSPs
- 转移到HCH，如果尚未转移到HCH
- 依赖于医疗保险在示范中的可融资性，为具有残疾的双重合格者

模型3：专门的ICSPs
精神、化学和物理健康
- DHS建立标准，为化学、精神和物理健康护理系统模型设立标准，以供具有严重精神问题的SMBI成员参加SNBC，示范期间
- DHS发布RFP
- 需要与县、MMICO、主要护理、化学和精神健康提供者合作
- 也可能包括非双重的SNBC成员
- 补充细节TBD与化学和精神健康以及继续护理
- 探索健康之家和/或HCH作为模型的一部分
- 标准化结果衡量指标
- 依赖于具有残疾的双重合格者的可融资性

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虚拟护理系统
- 通信工具
  - 模型1
<table>
<thead>
<tr>
<th>Model Features</th>
<th>ICSP Models 2 and 3 Payment Options</th>
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<tbody>
<tr>
<td></td>
<td>Payment Type A Performance rewards: performance pool or P4P</td>
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<tr>
<td></td>
<td>Payment Type B Primary Care/Care Coordination Payment Reform (PMPM or partial sub-capitation for primary care and care coordination)</td>
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<td></td>
<td>Payment Type C Sub-capitation or Virtual Capitation for Total Costs of Care Across multiple defined services including primary, acute and Long Term Care</td>
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<td>Payment Type D Alternative Proposals</td>
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<tr>
<td>MCO manages various provider contracts with LTC providers and/or Primary Care Providers designed to incentivize improved health outcomes and consumer choice of community and institutional settings.</td>
<td>X</td>
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<tr>
<td>MCO contracts with primary care under primary care payment reform models that include care coordination and health care home or health care home alternative payments</td>
<td>X</td>
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<tr>
<td>MCO delegates care management to Provider Care System/Collaborative (primary care providers with long term care providers) using risk/gain/performance payment model across services.</td>
<td></td>
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<tr>
<td>MCO contracts with providers to provide financial and/or performance incentives for Chemical and Behavioral Health coordination or integration can include HCH or Health Homes (mainly for SNBC)</td>
<td>X</td>
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<tr>
<td>Care Coordination</td>
<td>X</td>
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<td>Quality Metrics</td>
<td>X</td>
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<td>Financial Performance</td>
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<td>DHS Review</td>
<td>X</td>
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<td>Reporting Requirements</td>
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Dual Demo Stakeholders Website:
www.dhs.state.mn.us/DualDemo

Disability Managed Care Stakeholders Group
www.dhs.state.mn.us/SNBC