Agenda

- Welcome, Roll Call, and Meeting Purpose
- Finalize Preliminary Recommendations on Data Sharing Barriers
- Payment Models Supporting Integration of Care, Impact on Safety Net and Rural Providers, & Areas of Enhancement
  - Panel Presentation
  - Challenges and areas for enhancement
- Enhancements to Payments that Support Integrated Care Delivery
- Public Comment
- Next Steps and Wrap Up
Preliminary Recommendations on Data Sharing Barriers

- **Technical updates and clarifications to Minnesota’s Health Records Act** to leave a patient’s ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.

- **Provide ongoing education and technical assistance to health and health care providers and patients**, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.

- **Conduct a broad study** on the appropriate future structure, legal/regulatory framework, financing, and governance for HIE in Minnesota, building on lessons from other states and countries.
Preliminary Recommendations on Data Sharing Barriers – Further Discussion

- Dependent on results of HIE study, **consider other modifications to Minnesota’s Health Records Act**, to align with federal HIPAA standards or to update opt-in or opt-out requirements.

- Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to **enable smaller and specialty providers to participate in HIE**.

- Consider developing a **funding mechanism for core HIE transactions**, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide.

- Support the **establishment of robust, sustainable HIE “shared services,”** such as consent management, that would be available statewide through a central vendor.
Enhancements to Care Delivery

- Payment Models Supporting Integration of Care, Impact on Safety Net and Rural Providers, & Areas of Enhancement
  - Hennepin County Medical Center
  - FQHC Urban Heath Network
  - Southern Prairie Community Care
  - Monica Hurtado, Voices for Racial Justice
NOVEMBER 6, 2015

Enhancing Life and Health in our
Communities Through Accountable Care

Minnesota Health Care Financing Task Force
SPCC is a virtual network focused on the Triple Aim
Identified as an Accountable Community for Health
27 provider members - clinics, hospitals, public health, mental health centers, and area human service agencies
Focused on improving health of people in our communities.
The strength of our approach is efficiently mobilizing “the community” around those with highest need.
Ability to leverage connections in Governance of SPCC and that of HHS agencies, MHCs, and county hospitals.
Southern Prairie Community Care

Collaboration of 12 Counties

- Chippewa
- Cottonwood
- Jackson
- Kandiyohi
- Lincoln
- Lyon
- Murray
- Nobles
- Redwood
- Rock
- Swift
- Yellow Medicine
SPCC Governance Structure

- Southern Prairie Community Care
  - Joint Powers Organization - Extension of County Government
  - Governance by County Commissioner Representation
  - Contracted Entity for Integrated Health Partnership

- Southern Prairie Center for Community Health Improvement
  - 501c-3 Non-Profit Organization
  - Board Governance by Participating Entity/Stakeholder Representation
  - Governance Entity for Health Information Exchange Initiative: SPCLink
Current Contracts and Partners

- **Minnesota Department of Human Services – IHP Contract**
  - 3 Year Medicaid Demonstration
  - Year 2 – Inclusion of Mental Health Costs in TCOC
- **MDH/DHS Minnesota SIM**
  - Accountable Community for Health Grant – Diabetes Prevention
  - E-Health Grant for HIE Implementation
  - IHP Data Analytics Grant
- **Blue Cross Blue Shield**
  - 3 Year Agreement (through 2016)
  - Sustainability Plan in Process (2017 and Beyond)
SPCC/BCBS Agreement through 2016

- Enhance health plan relationships with the local network and DHS;
- Prevention, early intervention, and reducing the total cost of care.
- Develop locally driven care coordination model with rural emphasis
- Investment in “Total Population” Health Information Exchange (HIE);
- Total Population Focus – Across 12 County Network
- Lessons learned allow for replication in other rural parts of Minnesota;
Health Care Financing Task Force
Information: www.mn.gov/dhs/hcftf
Contact: dhs.hcfinancingtaskforce@state.mn.us
Staff Model to Support Mission & Values

- Specific expertise recruited to support development
- Complementary knowledge, skills and abilities of staff members at each level
- Blended model – includes both hired staff and grant funded positions
- Hired staff are employees of Joint Powers
2014 IHP Settlement (DHS)

- SPCC Contract began April 1, 2014.
- SPCC was responsible for just over 18,000 Medicaid members.
- Spent over **4 million dollars less than projected**.
- SPCC has earned a settlement distribution of $1,546,678.99
- SPCC distributed $1,546,678.99 (100%) of shared savings received to-date to network providers
- 25% (subject to quality reporting) will be in addition to above and dispersed with final settlement.
Year 1: $4 million Saved

<table>
<thead>
<tr>
<th>Attributed Population</th>
<th>18,000 Medicaid Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost Avoidance</td>
<td>$4 million in FY 2014</td>
</tr>
<tr>
<td>Average Cost Avoidance</td>
<td>$221 per person</td>
</tr>
<tr>
<td><strong>Southern Prairie Dollars To Reinvest</strong></td>
<td><strong>$1.55 million for FY 2015</strong></td>
</tr>
<tr>
<td>Quality Bonus Available To Southern Prairie</td>
<td>$500,000 additional</td>
</tr>
<tr>
<td>DHS Savings Kept</td>
<td>$2 million</td>
</tr>
</tbody>
</table>
## IHP Payment Model – 2015 Target Update and Q2 Results

### CY2015 Performance - Target Update and Q2 Results

<table>
<thead>
<tr>
<th></th>
<th>2014 Updated Target</th>
<th>2014 Results</th>
<th>2015 Target</th>
<th>Q2 Adj Target (4/14-3/15)</th>
<th>Q2 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$390.79</td>
<td>$369.82</td>
<td>$445.97</td>
<td>$455.70</td>
<td>$430.54</td>
</tr>
<tr>
<td>Results</td>
<td>$200.00</td>
<td>$250.00</td>
<td>$300.00</td>
<td>$350.00</td>
<td>$400.00</td>
</tr>
<tr>
<td>Trend</td>
<td>$369.82</td>
<td>$47.75</td>
<td>$386.90</td>
<td>$430.54</td>
<td>$455.70</td>
</tr>
<tr>
<td>Additional MH/CD</td>
<td>$11.32</td>
<td>$5.5% vs. Target</td>
<td>$47.75</td>
<td>$369.82</td>
<td>$455.70</td>
</tr>
<tr>
<td>Standard TCOC</td>
<td>$386.90</td>
<td>$386.90</td>
<td>$430.54</td>
<td>$430.54</td>
<td>$430.54</td>
</tr>
</tbody>
</table>

### Q2 Results

- The 2% adjustment from the 2015 Target ($445.97) to the Q2 Target ($455.70) is most likely driven by a change in risk between the CY2015 and Q2 attributed populations.
- The change in risk was largely reflected in the claims experience, resulting in a minimal change to the experience vs. the target (5.5% below target in Q1 vs. 5.4% below target for Interim Settlement).
- Recently released Q3 results, reflecting the performance for the period from July 2014 to June 2015 shows performance at -4.4% vs. Target.

### 2015 Target vs 2014 Target

- 2015 Target reflects the impact of contractual changes to the agreement with DHS:
  - “Standard TCOC” adjusted from 2014 Updated Target to reflect a change in the catastrophic claims threshold ($200K vs $500K)
  - 2015 Target includes additional at-risk Mental Health and Chemical Dependency services
- Target was adjusted to reflect the expected trend from 2014 to 2015 (2.6%)
- Because the IHPs are allowed to realize the benefit of the observed savings over multiple years of the contract, the observed savings are not lower than Target.

### Health Care Financing Task Force

Information: www.mn.gov/dhs/hcftf
Contact: dhs.hcfinsancingtaskforce@state.mn.us
Barriers to Enhancing Care Integration

- “Pilot” Nature of Alternate Payment Arrangements
  - No clear sense of future, timeline, stability, standardization
  - Financial sustainability model remains uncertain – for integrated care and HIE

- Mix of Traditional and New Payment Arrangements
  - Not at tipping point where people are mostly focused on performance based

- Level of Variation Across Alternate Payment Arrangements/Models

- Data Related Barriers
  - HIE: Legal/Policy, Lack of Statewide Direction, Business Case, Vendor Readiness
  - Variability data across payers for Alternate Payment Arrangements

- Change Management / Staff Recruitment and Training
Payment Model Enhancements Needed

- Stable and Consistent Understanding of How the Model Works
  - Two components: Prospective Payment + Performance Payment
  - Payment to support integration of primary care with behavioral health
  - Planned, timed transition of total market (multi-payer alignment)
  - Adjustments in performance criteria to address barriers resulting from policy/design
- Policy and Purchasing Levers
  - Clear incentives to drive participation in data sharing for care & analytics
  - Address ambiguities and barriers in Minnesota privacy and consent laws
  - Clear statewide approach for health information exchange
  - Clear priorities and planned growth to build toward robust data exchange
- Standardization/Uniformity
  - Models for Attribution
  - Data provided by payers for management of attributed members
  - Care coordination/other services based on “likeness”—not pay source
Enhancements to Care Delivery

- Payment Models Supporting Integration of Care, Impact on Safety Net and Rural Providers, & Areas of Enhancement
  - Hennepin County Medical Center
  - FQHC Urban Heath Network
  - Southern Prairie Community Care
  - Monica Hurtado, Voices for Racial Justice
Next Workgroup Meeting

Friday, November 9th, 2015
2:00 pm to 4:00 pm
Room 2390, DHS’s Anderson Building
540 Cedar St.
St. Paul, MN