

Minnesota Accountable Health Model: State Innovation Model (SIM) Grant – DRAFT 11/20/13

Minnesota Accountable Health Model Vision

The purpose of the **Minnesota Accountable Health Model** is to provide Minnesotans with better value in health care through integrated, accountable care supported by innovative payment and care delivery models that are responsive to local needs. The Model will create an environment in which the following vision for delivery system transformation can be achieved:

- a. Every patient receives coordinated, patient-centered primary care;
- b. Providers are held accountable for the care provided to Medicaid enrollees and other populations, based on quality, patient experience and cost performance measures;
- c. Financial incentives are fully aligned across payers and the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care; and
- d. Provider organizations effectively and sustainably partner with community organizations, engage consumers, and take responsibility for a population's health through *Accountable Communities for Health* that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services.

Rather than simply cutting costs through decreasing access or services, Minnesota will save money in the health care system and improve health by realigning providers' incentives towards quality and efficiency and away from volume and providing more coordinated, prevention-oriented care. Ultimately, the Minnesota Model will begin to move providers and communities towards the vision of shared accountability for the total cost of health of a population, and partnerships to improve population health.

State Innovation Model (SIM) Grant Goals

The State Innovation Model (SIM) grant will achieve the Minnesota Accountable Health Model vision and support Triple Aim goals by providing investments in infrastructure and supporting providers and communities to begin to participate in, or expand their participation in, a range of accountable care models. SIM activities will support organizations and collaboratives that aim to: coordinate and integrate care and service delivery across the continuum; improve quality, patient experience and health outcomes; effectively engage communities; and reduce health care expenditures.

Overall Targets/Goals in Grant:

- **200,000 Medicaid enrollees in ACOs (HCDS) model**
- **60% of fully insured population in ACO/TCOC model: 1.72 million people (current: approx. 1.26 million)**
- **Savings: \$111 million (provide split by public/commercial)**

For the purposes of this document, the following definitions apply:

Accountable Care/ACO: A group of health care providers (in any care setting) that have collective responsibility for patient care and that coordinate services. This term is meant to include not only providers that are part of an existing ACO as defined by the Centers for Medicaid and Medicaid Services (CMS) or other payers, but also those that are moving towards greater financial accountability for the quality and cost of care they provide to their patients.

Community: A community may be a geographic area, such as a neighborhood, county, or city. It may also be a community of people who share a common identity and/or cultural perspective.

**State
Innovation
Model (SIM)
Grant Goals,
cont.**

1. Can we improve health and lower costs if more people are covered by Accountable Care Organization (ACO) models?

Care Delivery and Payment Transformation

- Participation in accountable care arrangements includes small and rural providers as well as larger metro providers, and happens without compromising patient choice or access to care.
- ACOs are prepared, able, and are willing to accept accountability for additional services beyond the core set of medical services, including additional behavioral health services, social/community-based services and long-term care service and supports.
- The state, in collaboration with payers, providers, and communities has defined base requirements and structures (regulatory/legal, operational, measures, outcomes) for ACO/ACHs, with a base model that maintains flexibility for various organizational structures and coalitions.
- ACO/ACH models have multi-payer commitment and alignment to drive system transformation and sustainability. Alignment does not require the exact same payment and requirements, but the incentives should align across payers.

Outcomes

- Evidence of better health and lower costs from the first round of HCDS and other ACO models, using new and existing measures that are aligned with statewide clinical and community/population health goals.
- Our statewide quality measurement system will allow us to understand and pay for achieving improved health outcomes at a community/population level, using measures that are meaningful to consumers as well as providers/payers, and that are aligned with other state/federal initiatives.

2. If we invest in data analytics, health information technology, practice facilitation, and quality improvement, can we accelerate adoption of ACO models and remove barriers to integration of care (including behavioral health, social services, public health and long-term services and supports), especially among smaller, rural and safety net providers?

Data Analytics/HIT/HIE

- Secure exchange of data between organizations participating in, or preparing to participate in, accountable care models occurs in a more seamless/real time way across settings (clinic/hospital/LTC/post-acute care/behavioral health/local public health/social services), for the purpose of more effectively identifying opportunities for improvement and coordination, with the ultimate goal of improving care/health.
- Providers participating in HCDS or other accountable care models have access to clinical data that support transitions of care, along with other identified priority transactions necessary to promote coordinated, high quality care across settings.
- The state has a roadmap for the secure exchange of clinical health information across providers/settings/communities, with specific roadmaps for behavioral health, long-term care, and social service providers and a focus on key transactions needed to support evolving accountable care or coordinated care models.

Care Delivery and Payment Transformation

- Resources, assistance and support are available for providers and communities to participate in accountable care models through integrated care models (e.g. primary care/HCH/behavioral health home, behavioral health, long-term care/post-acute care) to more effectively provide team-based care and implement change at the individual practice level.
- The state has implemented quality improvement initiatives and learning collaboratives that are tied to statewide clinical and community/population health goals and targeted to achieve cost savings for Medicaid and other payers.
- Organizations are prepared to offer team-based, patient centered care to all patients, and effectively integrate new types of health professionals (including community paramedics and community health workers) into their practices.

Services integration

- Organizations participating in accountable care models (including ACHs) are beginning to integrate services and behavioral health providers and/or social services or long-term care service and supports settings. This includes examples where partners are sharing upside and downside financial risk across sectors.

3. How are health outcomes and costs improved when ACOs adopt Community Care Team and Accountable Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models?

Care Delivery and Payment Transformation

- Organizations participating in accountable care models are beginning to establish robust working partnerships with community-based organizations and other partners (including employers, local public health, and schools) to form ACHs, with expanded accountability for community/population level health improvement
- Accountable Communities for Health have identified health and cost goals and strategies to move towards those goals, and have a commitment (including a financial commitment outside of grant funding) to continue their work into the future.

Services integration

- The state has a methodology and a roadmap for how non-medical services impact health care expenditures and health outcomes and how that is incorporated into accountable care delivery and payment model.

Community partnership

- We have created new, sustainable venues through which providers and communities engage in more meaningful ways to improve individual and community/population health – with accountability on all sides. This will be achieved through true partnership, not through new mandates.
- Participating ACH communities have brought a wide range of stakeholders and community members into the development and implementation of their community plans, as equal partners.

Outcomes

- The state will have a robust evaluation that assesses the impact of SIM in terms of costs, quality, disparities and health (broadly defined, vs. medical/clinical health).

Principles for SIM Investments

Overarching Principles:

- Funding and support will be used to incent movement towards greater participation in and lives covered under accountable care models, and/or towards models that include a wider range of services and community partners
- Funding and support will be targeted (geographically, by provider type/setting/size, etc.) to achieve the grant-specific goals
- Funding and support will be focused on improving care for distinct populations of patients with conditions that require significant coordination of care across provider and community settings, such as those with multiple chronic conditions or multiple life issues that create complex needs
- Support broad infrastructure investments as well as community/model/provider specific investments
- Funding will support models throughout the state, reflecting the range of where Minnesotans live and receive health care
- Leverage existing programs, infrastructure, innovations and investments wherever possible
- Share learnings, tools, best practices and results as broadly as possible
- Pair with policy and state law changes or additional federal approval

Priority will be given to models/communities/infrastructure that demonstrate:

- Specific goals/outcomes/evaluation that are clear and well designed, and aligned with Triple Aim goals for quality improvement, community/population health improvement, disparity reduction and cost savings
- Strong and collaborative relationships between providers, payers, community/patients/consumers, employers, and other stakeholders in the design and implementation of activities, including partnerships between healthcare providers and community-based, social service, and other organizations
- A clear plan to effectively and consistently engage patients and communities in their work, particularly those most impacted by disparities and/or experiencing complex needs, using culturally appropriate strategies.
- Potential to be replicated/expanded
- A strong and realistic sustainability plan
- Return on Investment (ROI) – savings to Medicaid, Medicare, and private payers during the funding period as well as, over a longer time frame, savings to other systems or stakeholders (employers, educational system, criminal justice system, housing, etc.)
- Multi-payer support and commitment
- Participation in or partnership with HCDS or other accountable care models or preparation toward participation in these models