

Factsheet: ACO Baseline Assessment

Introduction

Minnesota was awarded a \$45 million State Innovation Model (SIM) grant by the Center for Medicare and Medicaid Innovation (CMMI) to implement the Minnesota Accountable Health Model. The Accountable Health Model seeks to improve health in communities, provide better care, and lower health care costs. Central to this model are broad provider-based organizations, known as Accountable Care Organizations (ACOs), which manage the health care needs of a defined population, typically tied to some financial incentives.

The Minnesota Department of Health (MDH) commissioned IBM/KPMG to conduct a baseline assessment of the degree to which accountable care practices are present in Minnesota health care delivery system. This fact sheet summarizes certain key findings from the baseline assessment. The report, **“Baseline Assessment of ACO Payment and Performance Methodologies in Minnesota for the State Innovation Model (SIM)”** contains detailed findings and analyses of the ACO market in Minnesota.

The findings from this assessment will be used to inform SIM priorities and broader discussions related to how best to move towards statewide cost and quality goals.

Key Findings

The findings below demonstrate that while Minnesota has a strong history of integrated care, and ACO models are beginning to take root, the accountable care market is not yet at full maturity. There is much work yet to be done to achieve statewide goals for accountable care and system integration.

ACO PARTICIPATION

- Reported ACO participation in the commercial market in Minnesota is relatively high, with 41% of fully insured covered lives attributed to ACO modelsⁱ. However, participation is heavily concentrated among the largest health plans
- Based on clinical level data and survey information, approximately 50% of clinics, hospitals and physicians either belong to an ACO or belong to a larger organization that participates in an ACO.



Figure 1

ACO MATURITY

- The assessment rated organizations on their maturity across seven domains that are critical to the performance of a clinically integrated organization (described under “Approach”). The assessment showed a relatively low median ACO “maturity” level of 30% across all core competencies. The maturity rating was highest for competencies related to clinical decision support (40%), and lowest for disease management (10%) (Figure 1).
- ACO development and maturity is greatest among larger organizations in the state, with independent and specialty providers less likely to be in an ACO and relatively less “mature.”

INTEGRATION WITH ENHANCED CLINICAL AND NON-CLINICAL SERVICES

- Most ACO arrangements in Minnesota are hospital-focused. Few ACO-based organizations have revenue or risk-sharing contracts that include long term care, behavioral health, or non-clinical services. Only a quarter have contracts that include community-based service providers.

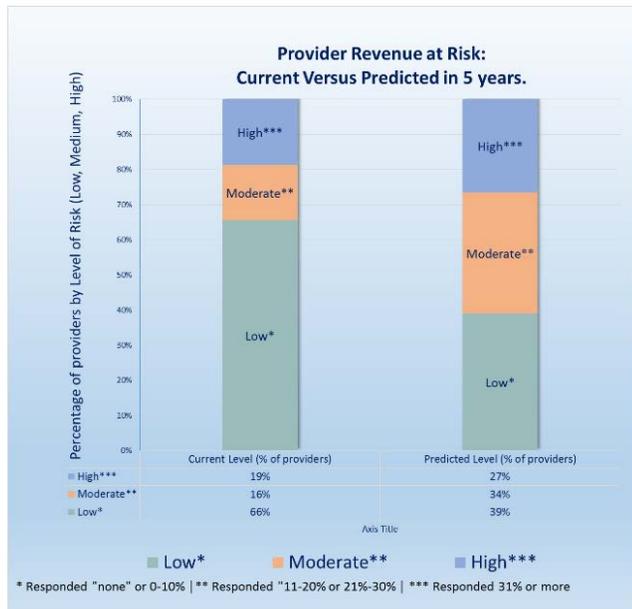


Figure 2

- Sixty percent of respondents cite behavioral health as a “very important” priority for enhanced clinical services in the future, followed by long term care (35%), social services (32%) and public health (31%).
- Respondents indicated a number of opportunities to support additional ACO development and integration with enhanced clinical and non-clinical services, many of which align with SIM priorities such as support for care coordination that includes community-based resources, data analytics, investments in data/technology infrastructure at the provider level, private sector access to the APCD, pilot funding, and education on ACO and population health concepts.

REVENUE AT RISK

- The percentage of revenue currently at risk in ACO or similar arrangements is low, with two-thirds of providers indicating that 10% or less of their organization’s revenue is at risk. Providers anticipate this percentage to increase in the coming years; a quarter of respondents expect to see more than 30% of their revenue at risk five years from now. (Figure 2)

Approach

Minnesota approached the baseline through the lenses of providers and health plans, where accountable care activity and innovation occur. The assessment used structured interviews with key informants from five health plans, five medical groups, and two community organizations. The assessment also included a web-based survey using fixed and open response questions, with different survey paths for medical groups and hospitals (referred to as “providers” throughout the report), and health plans. The survey was analyzed using the **IBM/KPMG Clinically Integrated Entity (CIE) Target Operating Model ©**.

SURVEY RECRUITMENT AND DEMOGRAPHICS

Survey participants were recruited using statewide contacts for health plans and providers at the medical group and hospital levels. Of approximately 400 providers and health plans contacted, 65 providers and eight health plan representatives responded. Provider participants responded at various levels within the organization, some from a wide, integrated delivery system perspective, and some from a single clinic or hospital perspective. Participants were representative of state demographics with all regions responding to the survey. Participants in six out of eight regions report belonging to an ACO (Figure 3).

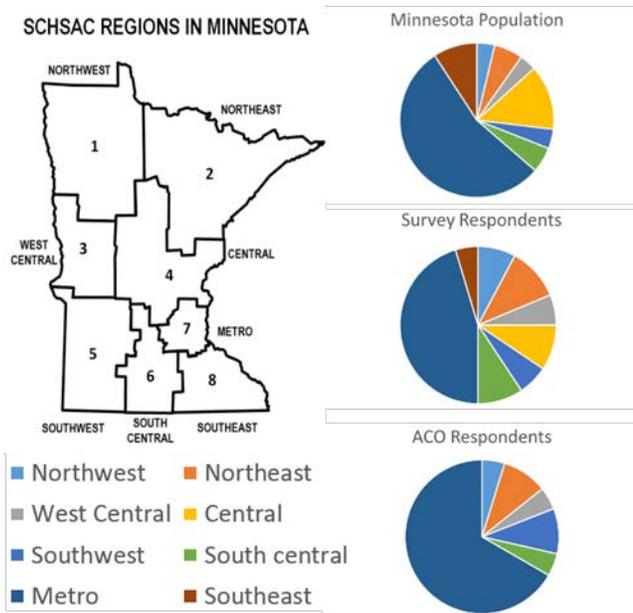


Figure 3

Provider respondents included a broad spectrum of community organizations and specialty clinics as well as integrated delivery systems and medical groups (Table 1).

Table 1: Provider Types (could select more than 1)

Organization Type	#
Community mental health organization	2
Federally Qualified Health Center	2
Home health agency	5
Hospital	19
Integrated delivery system	15
Long Term Care/Post-Acute Facility	10
Medical specialty clinic or specialist group	24
Non-profit community-based care	6
Primary care clinic or medical group	23
Rural Health Clinic	8
Other	3

MATURITY MODEL CORE COMPETENCIES

The assessment used the **IBM/KPMG Clinically Integrated Entity (CIE) Target Operating Model** © as a reference point for assessment design, recommendations and discussion. The domains for the target operating model include;

Population Health Management – identifying care needs and providing population health management

Disease Management –care coordination, evidence-based practices, provider services, measurement and quality improvement, and program management

Patient Engagement – patient services, improved patient convenience, patient education, patient involvement, and patient satisfaction.

Case Management – case assessment, transition of care management, gaps in care analysis, remote monitoring and management, readmission management

Clinical Decision Support – patient diagnosis, secondary preventive care, planning or implementing treatment, follow-up management, hospital provider efficiency, evidence-based standards.

Performance Management – core performance measures, patient experience measures, practice performance reporting, reporting performance publicity

Utilization Management – authorization of care, comprehensive utilization review, peer review, standards and compliance, appeals and grievances, analysis of utilization, costing and savings analyses.

Report Recommendations

IBM/KPMG recommends the following:

- Establish consistent top-down leadership and support of the ACO model
- Combine increasing downside risk with support structures and tools to assist specialty and smaller providers
- Strengthen the culture of transparency (e.g. sharing quality information with providers, patients and the public) and collaboration among providers, families, and social service partners
- Invest in data and technology and meaningful use of them
- Focus on proactive management of complex populations

- Provide further exploration and education on ACO methodologies and population health
- Leverage existing data resources and analytics, such as Integrated Health Partnership (IHP) supports or the state's All-Payer Claims Database (MN APCD), and State Quality Reporting Measurement System (SQRMS) reporting in a manner that supports adoption of quality-based standards; and investigate policy levers and other ways to encourage clinical collaboration and population health management
- Work with stakeholders to define Accountable Care Organization and integrate population health concepts with the provision of prevention and provision of medical care
- Seek opportunities to remove barriers and identify best practices, especially regarding the needs of small, independent, and specialist providers
- Improve and build upon quality measures, with easier access to information that will enhance clinical integration to improve quality and lower costs

Next Steps

Report recommendations support many current SIM grant priorities, and help to identify ongoing priorities that will provide critical support for the development of ACOs in both commercial and public insurance markets.

Specifically, continued SIM activities will:

- Work with stakeholders to further refine SIM goals and priorities
- Refine data collection methods and monitor ACO activities within the state

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ⁱ Estimate based on survey data and information collected post-survey