

Baseline Assessment of ACO Payment and Performance Methodologies in Minnesota
for the State Innovation Model (SIM)

As prepared for:

**Health Economics Program
Minnesota Department of Health**

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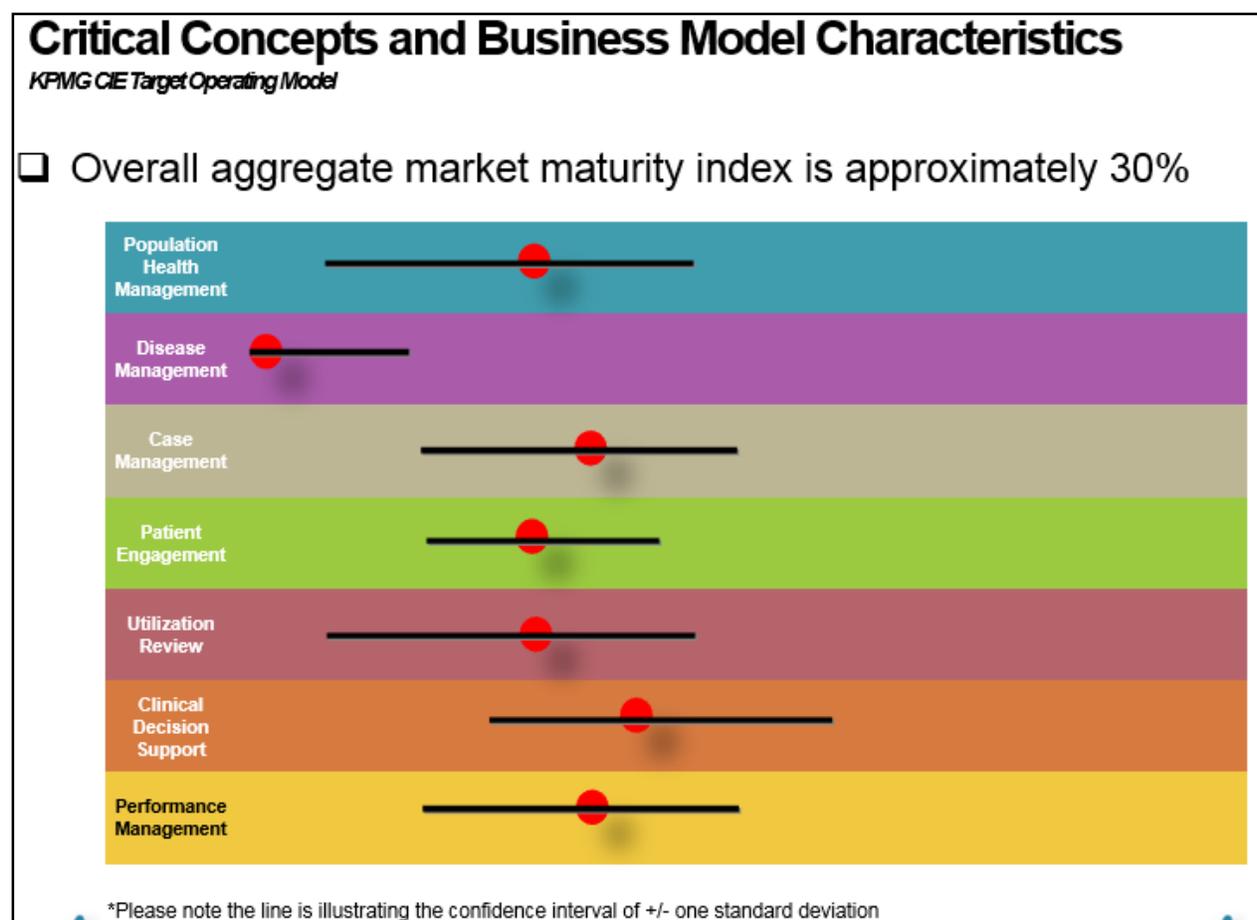


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Executive Summary

The Minnesota Department of Health (MDH), assisted by IBM and KPMG, completed this project to better understand the development of alternative care models in Minnesota and to establish a baseline for tracking market development. This project is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.



To gauge development of Accountable Care Organizations (ACOs), IBM/KPMG relied on a combination of qualitative interviews with healthcare leadership and a fixed-response web-based survey distributed to healthcare leadership and administrators. These observations were benchmarked against the KPMG Clinically Integrated Entity (CIE) Target Operating Model. The model illustrates increasing levels of development

across competencies considered to be critical to the performance of a clinically integrated entity, of which an accountable care organization (ACO) is a subset. Medicare Shared Savings Program (MSSP) participating ACOs are a further subset of the general ACO category. A score of 100% in the CIE Target Operating Model implies consistent application of the full breadth of capability, as well as demonstrated market leadership and innovation across each critical competency. This report summarizes the results of the interviews and the web-based survey.

Based on survey responses and detailed interviews, we estimate that the relative maturity of the ACO business model within Minnesota, as benchmarked against the CIE Target Operating Model rubric, is approximately 30% overall, which can be considered an “in development” result (as compared to “beginning” or conversely, “mature”). The quantitative measure is derived from maturity indexes identified for each business model characteristic as illustrated in the chart above. Based on this model, the highest developed business characteristic, also called a “contributing competency,” in the Minnesota market was clinical decision support. The least developed competency in Minnesota’s model is coordinated disease management. Between these two competencies, there is wide disparity of development within the other competencies, including population health awareness and management, effective utilization management, and performance management.

There appear to be three distinct clusters, or levels, of market maturity within Minnesota. One cluster has no alignment with ACO characteristics, and another cluster appears to have ACO-like business models that are in development, but are not yet achieving clinical integration, value-based performance alignment, or population health mentality. There remains one small cluster of participants with strong clinical models who are pursuing risk arrangements.

In general, survey participants report modest ACO participation with integrated care, and have varied expectations on ACO business model growth over the next five years. Further, current business model development is focused primarily around the hospital, with very few ACO-based organizations considering non-clinical services within their continuum of care. However, despite lacking these services, it is a common

management perception that the needs of the community are being met. Community may be too narrowly defined by management to be the patient population versus the population at large.

The market analysis indicates that top priorities going forward in the development of ACO business models are likely to be focused on organizational structure, business processes, and technology. These priorities include:

- **Change management:** Consistent top-down leadership within the ACO stakeholder community was cited as a significant contributor to ACO growth, but something needing focus and development.
- **Data Analytics:** Moving toward value-based / quality-focused reimbursements that include downside risk, as well as bridging the gap from the existing volume-based reimbursement methodology, is needed to align incentives and encourage change within the care delivery community.
- **Culture:** Greater industry transparency and cross-department collaboration in operations, process, and analytics is needed to build trust, partnership and, ultimately, clinical (care delivery and care management) integration.
- **Data and Technology:** Technology capabilities in the areas of transformative analytics, health information exchange, 360° view of the patient and evidence-based outcomes were cited as mission-critical initiatives.
- **Process Improvement:** Proactive management of populations with complex and chronic clinical conditions is cited by both health plans and providers as a significant to-do and very necessary.
- Survey participants cited pilot funding, education, and private sector utilization of an all-payer database as potential government initiatives to promote ACO adoption.

In summary, the analysis is represented well by one participant quote: “We are going in the right direction, but have a long way to go.”

Possible Next Steps for MDH

- Sponsor education on ACO and population-health concepts
- Sponsor education regarding the availability of data sources to support business model transformation
- Revise and update questions to further analyze areas of interest

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- Explore opportunities to expand the ACO business model, focusing initially on clinical integration and collaboration with non-affiliated, community-based service providers, especially as it impacts disease management
- Explore ways to leverage the Integrated Health Partnership (IHP) data analytics and State Quality Reporting Measurement System (SQRMS) reporting in a manner that supports adoption of quality-based standards
- Investigate potential regulatory solutions to enable population health minded clinical integration and organizational efficiency

Introduction

While change is a constant in every industry today, few are changing as rapidly as healthcare. As the transformation to a consumer-centric business model continues to gain momentum, the healthcare industry could see more change in the next three years than it has seen in the last thirty. The consequences of this transformation are far reaching. In the quest to achieve the *Triple Aim* (improve the health of the population, the patient/consumer experience, and the affordability of care), caregivers are challenging pre-conceived notions of the optimal clinical path, considering new services to address the needs of their population, and collaborating with both medical and non-medical service providers to address the healthcare needs of the patient more holistically.

Accountable Care Organizations (ACOs) present a recognized pathway to achieving these goals, and it was the purpose of this initiative to measure the maturity of ACO-contributing factors across the state and various healthcare delivery stakeholders. This initiative gathered information through a series of qualitative interviews with healthcare leaders, and a broadly distributed web-based survey that included a wide range of Minnesota healthcare organizations.

Engagement objectives included:

- Create a baseline of the current ACO marketplace in Minnesota, including number of covered lives, organizations claiming ACO status and providers participating in ACOs.
- Create a high-level perspective on the impact of ACOs in the targeted communities, including the challenges faced thus far, the steps taken to begin to address these challenges, and the effectiveness of those steps.
- Create a repeatable process to gauge progress.

Through this project, MDH sought to improve its understanding of the development of alternative care models in Minnesota with an emphasis on ACOs and to establish a baseline for tracking market development. This project is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments

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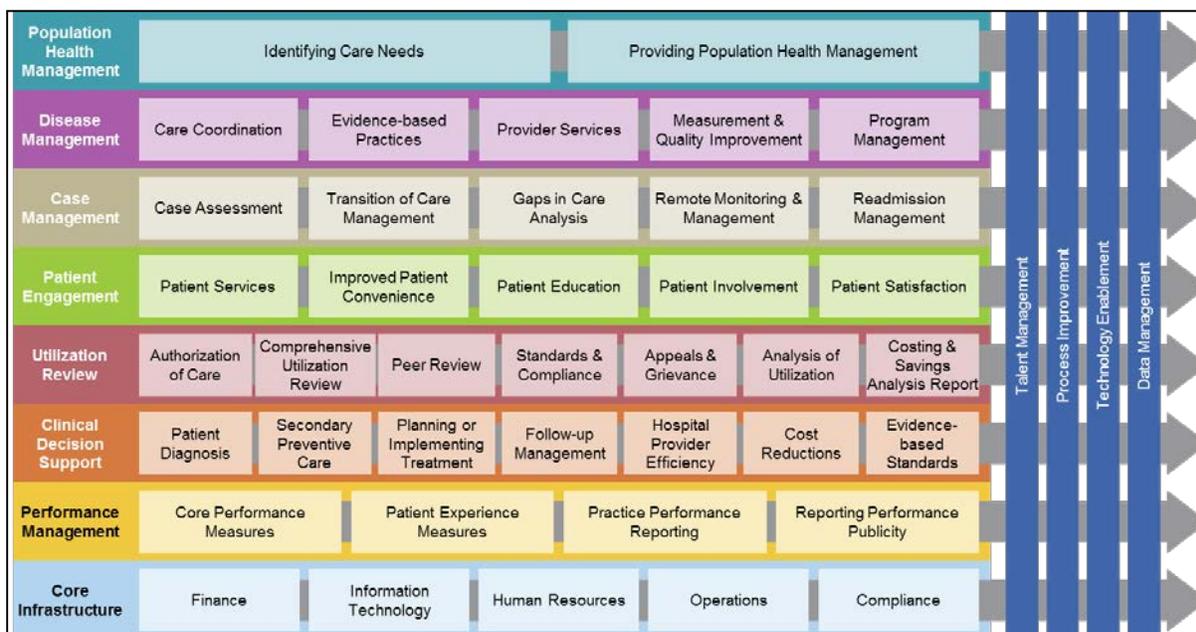
of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model. Furthermore, it intended to understand methods of achieving quality, cost and access goals in Minnesota while identifying current barriers, policy implications and ways to better enable development of alternative care models. Lastly, it is looking to build upon the existing ACO taxonomy.

Given that one of the Triple Aims relates to affordable care, a key consideration is an understanding of alternatives to fee-for-service (FFS) payment arrangements. MDH is looking to understand the level of payer participation in performance-based or value-based payment, with the objective to align and evolve ACO payment methodologies and develop financial measures for integrated team-based models.

Description of Approach

For this project, IBM/KPMG leveraged the KPMG Clinically Integrated Entity Target Operating Model for the purpose of translating both qualitative statements and survey responses into a quantifiable maturity index. The model identifies discrete competencies (e.g., Population Health Management, Disease Management) supported by specific attributes and guidelines for maturity measurement. The graphic below illustrates the building blocks that are anticipated to be part of complete development of the various capabilities of an ACO. The prevalence of these building blocks creates a sense of relative maturity within each competency. The results below discuss these competencies in more detail.

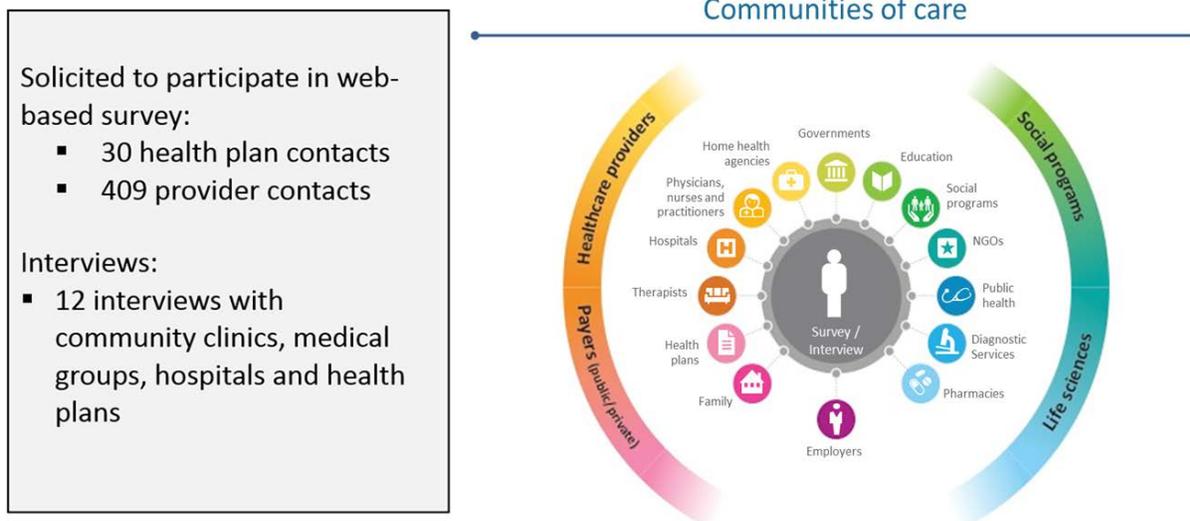
Illustration of KPMG Clinically Integrated Entity Target Operating Model



The interview population represented a mix of senior healthcare leadership across the care delivery spectrum complemented with broad distribution to healthcare delivery participants for the web-based survey. This stratified approach ensured representation from key organizations while also including smaller, geographically dispersed organizations. Survey participation proportionally represents patient population by geographical region, while including responses from leading health systems/health plans. Survey participation was representative of the State of Minnesota, and is known

to be not comprehensive for all health plans and providers. See Appendix A for more information relative to the distribution and representation of survey participants.

Stakeholder Universe – Who Was Asked to Participate



Survey Organization and Target Issues

Both the online survey and the interviews captured contact/demographic information before delving into ACO/CIE business models, contracting and relationships, quality management initiatives and processes supporting transparency and communication.

Interview participants were provided latitude to expand as appropriate on particular topic areas which represented a particularly significant theme for their organization.

Following is the list of topic areas:

- Clinical path
- Cost reductions
- Provider incentives to minimize unnecessary utilization of services
- Raising start-up capital for activities
- Developing a workable governance structure
- Measurement or reporting requirements
- Expenditure benchmarks

- Attribution methodology and developing and using internal performance tools
- Developing clinical and management information systems
- Developing physician leadership to encourage accountable care development
- Increasing the size of the covered patient population
- Contracting process and requirements, including legal challenges and anti-trust considerations.

The survey data will be used in determining a benchmark for future surveys, and future surveys will provide a measure of progress.

Online Survey

The web-based survey tool led the participant through the survey questions, allowing the user to select the most appropriate response available. Respecting their different roles within integrated care delivery, two response paths were provided, one for providers and one for health plans.

Users were prompted to fill in the blanks as indicated to provide maximum data and to justify/explain reasoning. A response to each question was required, including contact information. The length of the survey was minimized to maximize participation and survey completion. Please see Appendix B for a detailed listing of the actual survey questions. Questions were designed to follow a patterned response to maximize survey data quality (e.g., ranking 1 through 5). To encourage survey completion, survey participants were allowed to click on “Save” to save and pause during the survey, then return later to complete and click “Submit”.

Interviews

The interviewees represented a mix of medical group, hospital and health plan organizations. All participants were assured confidentiality in terms of any specific discussions. Thoughtful, open-ended interview discussion allowed for more robust information. Logistically, the interviews represented a combination of on-site interviews and conference calls to accommodate scheduling and location of the participant. While flexible, the discussion was structured around the CIE Target Operating Model, offering a complement to the online survey. A discussion outline and structure were reviewed with MDH to ensure coverage of information needs. The discussions were scheduled

for 45 minutes in length, and multiple consultants were present to separately record notes with one individual acting as discussion leader. All interviewees were highly engaged in the process, as evidenced by an ease in scheduling (interviewees made themselves available) and the length of the interviews which often lasted an hour.

Integrating Web-based Survey with Interview Findings

IBM/KPMG applied a rigorous process to integrate the interview discussion with the web-based survey.

- **Online Survey Analytics**

Each question was mapped to the appropriate category within the CIE Target Operating Model. Separately, survey responses were individually charted and analyzed. Survey responses were rolled up by the broader category assignment for maturity indexing.

- **Interview Analytics**

Each consultant submitted their individual notes to one note compiler. Once the notes were compiled into a single document encompassing all individual notes in an organized fashion, they were reviewed by the full team for completeness and used for analysis. The notes were assigned to the relevant category as represented in the CIE Target Operating Model for maturity index assignment.

Leveraging the maturity index assignment based on both survey responses and interview discussion, these individual category assignments were equally weighted to arrive at a single maturity index. These category-specific maturity indexes for both survey and interview participants can be found on the scatter plot graphs within the Detailed Findings section.

Challenges to ACO Assessment

Representing a complex topic, participants applied competing definitions for ACO, integrated delivery and other healthcare terms. Due to the variation among and across participants, there were challenges related to interpretation. Specifically, the provider participant community included both large medical centers as well as specialized medical groups. Attempts to validate survey findings through interview and follow-up

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phone calls were done to clarify some of the discrepancies noted. To maximize survey completion, some areas were not as heavily investigated which presents an opportunity for follow-up in subsequent surveys and analysis. As the market continues to mature, this tool and analysis is expected to represent an ongoing process where MDH will be reviewing previous results as well as compiling new results in the coming years.

By design and in consideration of privacy considerations, survey results were not stratified by region, stakeholder type or size of the organization. Participation was impacted by the availability of staff to complete the voluntary survey.

Summary of Findings

The summary of findings is organized with the quantitative web-based survey results followed by a discussion on ACO maturity and opportunities for growth incorporating both survey and interview findings.

ACO Participation

Survey participants (65 providers and 8 health plans) are geographically representative of the patient population and include leading health systems/health plans. For purposes of clarity within the report, provider is used to refer to hospitals, medical groups, and clinics. Approximately one-third of provider participants in the survey are currently in an ACO and six of the eight health plan survey participants currently have contracts with ACOs.

Of these active ACOs, commercial membership is the most significant payer with both health plans and providers reporting hundreds of thousands in covered lives. Based on survey responses in aggregate, the commercial market represents 60% of provider reported total covered lives, and 90% of health plan reported covered lives. Covered lives cannot be uniquely added across survey responses as an ACO may be represented in multiple survey responses.

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As illustrated in the graph below, survey respondents represent significant variation in size of their ACOs.

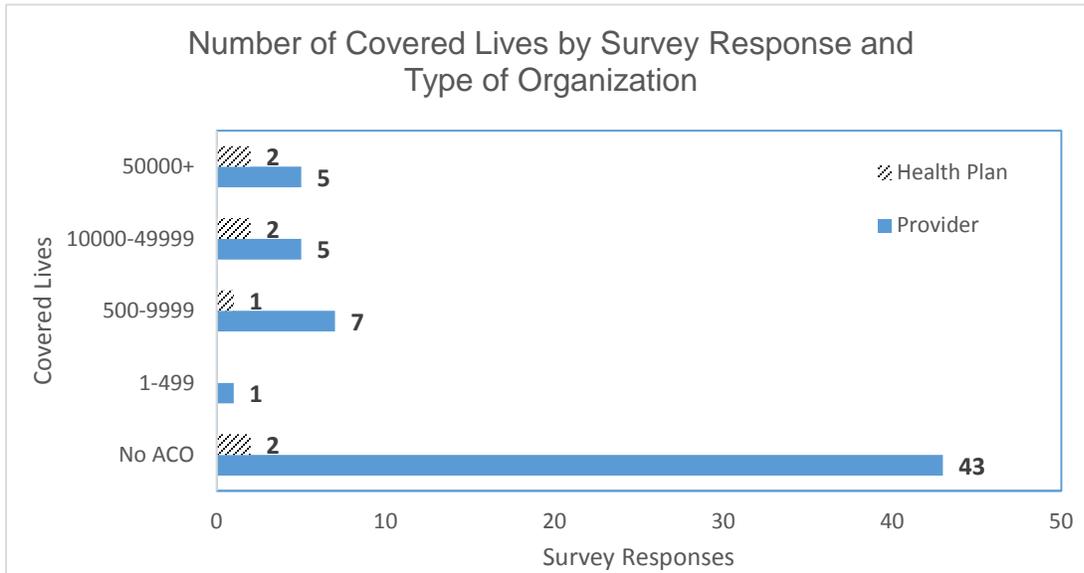


Table 1

Excludes four provider survey responses reporting ACO participation with a total of 0 covered lives. Health plan survey respondent data consolidated for one health plan with two survey responses. ACO reporting may not be unique to one survey response.

Of survey participants participating in/contracting with an ACO:

- More than 80% report 100 or more physicians are part of the ACO
- More than 50% report 41 or more clinics are part of the ACO
- More than 40% report 7 or more hospitals are part of the ACO

ACO Maturity

Survey responses illustrate a strong understanding of population health and a history of integrated care in Minnesota. One-third of providers report being part of an ACO business model. ACO development has been largely hospital focused; health plans have focused on at-risk contract arrangements with hospitals and targeted medical groups. The survey also illustrates that very few ACO-based organizations consider non-clinical services within their continuum of care (survey questions 28, 30). However, management perception remains that the needs of the community at large are being addressed (survey question 34).

Based on survey results and interview feedback, health plan system development and maturity appear to also be uneven, as is the sophistication and complexity of product design and network management approaches. As a result, passive attribution methods which assign patients to providers based on specific criteria or measurement, as opposed to enrollment or explicit selection, are the most common enrollment process, further limiting the popularity and utilization of ACO-based networks at this time.

Challenges to Increasing Adoption of ACO Models

Survey participants experience a wide range of challenges and obstacles to growth in integrated care delivery in the marketplace:

- Legal and regulatory hurdles, resource availability, and IT maturity
- Culture, education and training are also described as significant barriers to the ACO business model advancement; significant assistance and investment is needed in these areas in particular
- Availability of data that all consider accurate is also a challenge; participants are interested in the information available through the Minnesota all-payer claims database (*MN APCD*)
- Financial hurdles related to reconciling service delivery with existing reimbursement methodology, and managing risk, are common challenges

- Health plan product design needs to better align patient engagement and therapeutic compliance

Looking Ahead / Opportunity

Survey participants clearly, and consistently, communicate the following opportunities for developing the ACO business model and providing more integrated care:

- Opportunities exist to expand the ACO business models, as current models appear to be focused on hospital organizations and have moderate amounts of clinical integration.
- Both health plans and providers believe that more training and education are needed in order to increase the understanding, and potentially acceptance, of providers toward risk-based contracting.
- Proactive management of populations with complex and chronic clinical conditions is cited as necessary by both health plans and providers.
- Providers want more tele-health developed for mental health and specialists.
- Building more consensus and education about what “quality” means and how to measure it were also targeted as items that would be helpful. Quality measures collected by the state have different requirements than those collected by CMS. More revenue and operational management is being driven by CMS considerations. Quality requirements are being driven by CMS. The market follows the CMS standards and the HEDIS measures by a wide margin over other standards; however, transparency of those quality scores is not uniform.

Industry Next Steps to ACO Maturity and Improved Healthcare Delivery

Survey participants conveyed the specific changes necessary and actionable next steps to move the market forward to ACO maturity and delivery on these opportunities.

Organizationally, survey participants identified the following needs:

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- Consistent top-down communication and leadership regarding ACO business model development within the organization
- Cross-department service delivery such that personnel actively collaborate across medical and social services
- Resource availability to accommodate new roles and tasks related to care coordination and patient engagement

In consideration of contracting, next steps include:

- Expanding both upside and downside shared risk arrangements
- Preparation/education of the market for widespread use of alternative reimbursement schemes, including capitation
- Focus on specialist community to manage intensity and site of utilization and create a clinical team-based attribution approach
- Provide a funding mechanism to manage risk during the transition away from FFS/utilization-based reimbursement. Too much change in care delivery (e.g., less utilization, lower rate of admissions, fewer diagnostic tests) in the short-term may introduce unintended downside financial exposure.

From a data analytics and decision support perspective, the following next steps were identified:

- Enable timely 360° view, or complete picture, of the patient, including current condition, supporting services, and prior treatment. This may also include information about socio-demographic information, such as living conditions, proximity of family caregivers, interaction with advisors or counselors, and church/social organization affiliations.
- Enhance data availability and analytic capabilities to define best practices
- Physician “championship” for evidence-based outcomes

Lastly, from a process perspective, the following steps were identified:

- Embrace transparency in operations, data analytics, and methodology

- Incentivize all parties involved in care delivery to migrate to a higher level of ACO maturity
- Potentially outsource care management to an impartial 3rd party
- Maintain patient choice; closely monitor application of narrow networks
- Move towards current and potentially real-time and claim-level, risk-based payment calculation in lieu of reliance on historical, and retroactive financial adjustments that incorporate a periodic (e.g., semi-annual) settlement process

MDH Support and Policy Considerations

Survey participants also conveyed opportunities applicable to MDH for encouraging and accelerating ACO-based business model maturity in the marketplace. The observations and suggestions collected reflect a general consensus that organizational and data/analytics were the two areas needing the greatest support. It is worth specifically noting that participants were all well aware of the Minnesota Community Measurement, and spoke to its current value in managing population health. Perhaps just as interesting, many participants were not aware of the Minnesota all-payer database, relative to its potential use to understand total cost of care, generate outcome analytics and define best-in-class practices.

Support and policy considerations include:

- Policy support complemented with minimum regulatory intervention (e.g.; anti-trust considerations); support the need for a nimble environment
- Build on existing successes using existing advisory boards and dashboard metrics (e.g., Minnesota Community Measurement frequently cited)
- Promoting development of a health information exchange
- Fund a migration from FFS, utilization-based reimbursement
- Promote incentives to change the provider community from within
- Medicare/Medicaid leadership – Move dual-eligible into value-based reimbursement

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- Pilot support for targeted initiatives, such as reducing the rate of readmissions for patients with congestive heart failure, and reducing visits to the Emergency Department (ED) by identifying and communicating alternate care options
- Provide evidence-based outcomes analytics. Participants state there is great collaboration on defining best practices, but competition becomes more focused during execution of the practices defined. Clinical protocol is described by survey participants as industry-standard and not proprietary. The execution of the clinical protocol is where the provider has the opportunity to deliver excellence and gain a competitive advantage. Support the development of 'quality' as discussed above.
- Provide ICD-10 readiness training. Bundled payment methodology is driven by diagnosis/procedural coding
- Deliver predictive and transformative analytics to parallel and complement business process changes; move beyond trend reporting which is historical and not timely in nature and not as comprehensive / inclusive.

“Recognizing that the rate of change in the healthcare industry is not likely to slow down anytime soon, any policy considerations and supportive analytics need to recognize that ACO modeling is not an end-state. The path is not defined, the end-state is not known.”

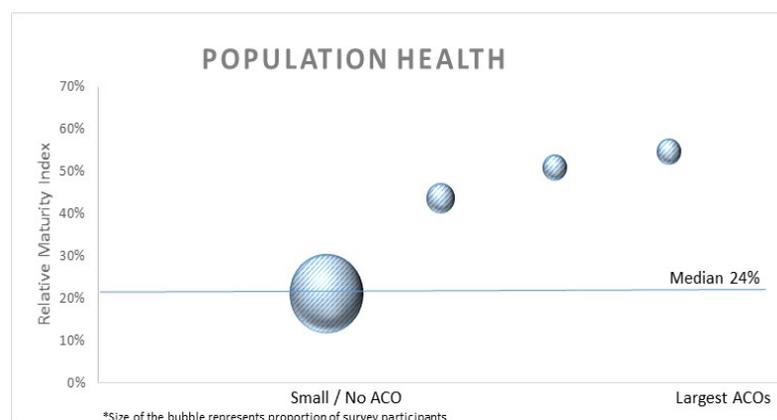
– Survey participant

Detailed Findings of the ACO Survey

Minnesota maturity relative to ACOs as measured through the Clinically Integrated Entity Target Operating Model is approximately 30% in aggregate. The overall maturity index is derived from the analysis of responses aligned to specific competencies, e.g., the prevalence of population health management, the sophistication of disease management, the comprehensiveness of clinical decision support, etc. The analysis is equally weighed across the various competencies within the CIE Target Operating Model to arrive at an overall index. The following sections provide supporting evidence and documentation relative to industry performance in each of the contributing categories within the model.

Population Health Management

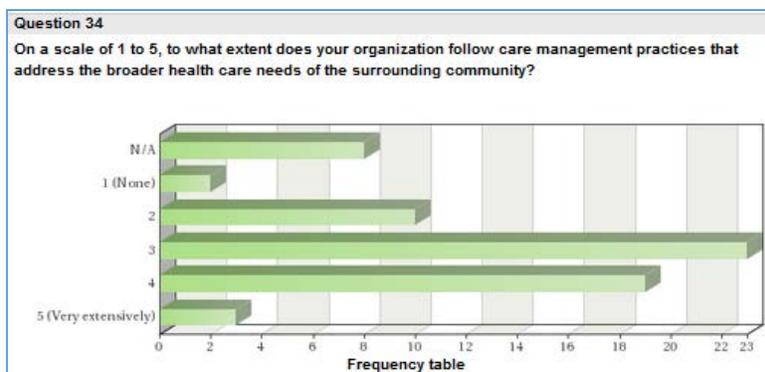
Based on the CIE Target Operating Model rubric for ACOs, full development of Population Health Management competency means identifying care needs proactively through population-based screening and analysis. This then drives clinical delivery and decision support in the delivery of care and education to the population at large, not just patients.



The chart above illustrates the current maturity level of participating providers in the area of population health management. The graph illustrates a high number of respondents had little to no ACO-based participation (i.e., a higher concentration of the market is illustrated by a bigger bubble). The largest ACOs in terms of size of reported membership in the survey represent a small number of survey respondents (therefore, a

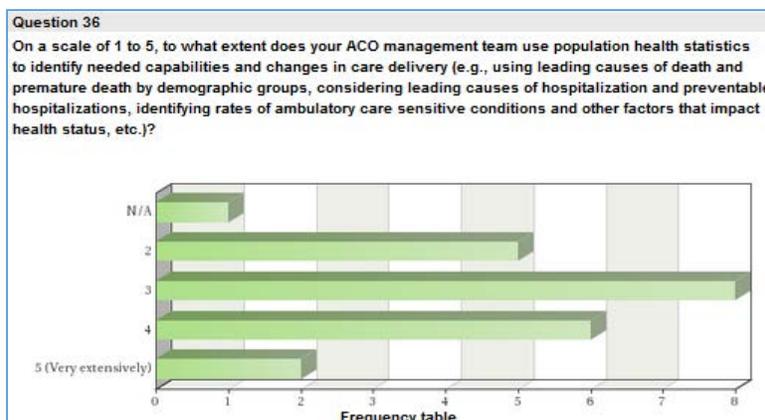
small bubble). All the competencies illustrated in this analysis are represented by a similar chart or analysis. Both providers and health plans show moderate maturity relative to population health management, with median relative development of 24%. As noted above, the market is dominated by a number of organizations that are not participating or have limited participation in ACO business models (more than two-thirds of respondents; the bubble size in the chart corresponds to number of respondents within that size category, as defined by enrollment). A consistent theme conveyed by all survey participants was an understanding that more needs to be done in terms of identifying and managing the health of the population regardless of the maturity of this competency.

In the detailed survey responses, approximately one-third of provider participants believe their organization follows extensive/very extensive (4 or 5 out of 5) care management practices that address the broader healthcare needs of the community. As the chart illustrates, however, there are still a significant number that see no or limited understanding of community-based clinical needs (scoring a 3 or lower).



Similarly, of provider survey respondents participating in an ACO, one-third report the extent to which the ACO management team uses population health statistics to identify needed capabilities and changes in care delivery as extensive/very extensive (4 or 5 out of 5).

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In more than one instance, survey participants describe the formation of a community task force developed to discuss opportunities to improve healthcare in the community and improve the quality of care. Providers are expanding care delivery through both horizontal and vertical means, blending organic growth and acquisition direction. However, as one participant said: *“To improve the care of the patient, the goal is NOT inherently to be integrated.”*

There was consistent recognition that increased involvement of social services, public health organizations, and involvement from the broader continuum of healthcare delivery stakeholders, including elected officials, schools, and charitable organizations, such as United Way, results in more communication, collaboration, and, ultimately, more effective population health management. There was also an understanding or desire to build cross-department integration both within and between organizations as a means to more effective population health management. Initial efforts to physically co-locate services resulted in increased collaboration and integrated care. To achieve a higher level of maturity, providers are looking to redesign clinical practices to be more population-health focused, reaching beyond clinical treatment to affect behavioral change, and include lifestyle management. Participants identified needing to balance traditional care delivery with a need to also respect the growing immigrant population, which has diverse healthcare and social needs. There is some evidence of proactive health management; for example, in one circumstance a proactive screening program was implemented for people who may be pre-diabetic.

In terms of next steps, a consistent theme describing proactive management of populations with complex and chronic clinical conditions is cited by both health plans and providers as very necessary. A related theme describes the resource and technology challenges being faced which impede progress. One survey participant described the use of a mapping tool to provide a geographic view of the region and identify *hotspot* regions with population health opportunity. Most, if not all, participants described the lack of available and timely data to identify population health needs as a challenge. Recognizing the need to manage population health as part of integrated care delivery, one participant explicitly stated:

“... We need a strategic population health plan in the next 5 years.”

Survey participants outlined the organizational recognition of change and need for dedicated resources, such as population health director roles, population health business units, etc., as necessary to drive this competency development.

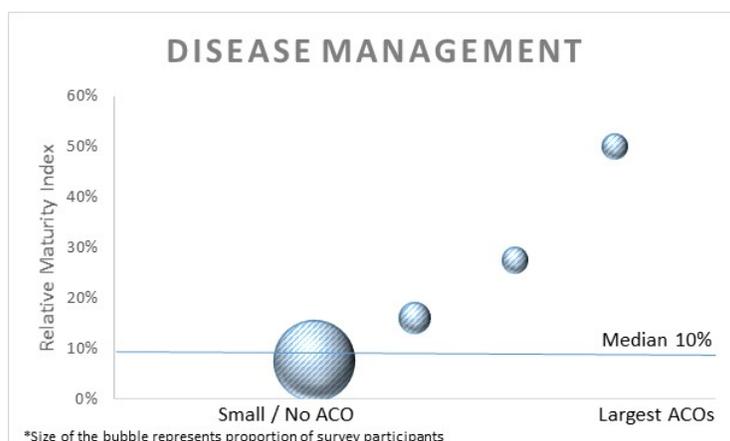
Disease Management

Based on the CIE Target Operating Model rubric for ACOs, full development of Disease Management competency means creating a high-touch environment involving the patient and provider in a manner that drives care planning and care continuity with routine performance evaluation related to evidence-based standard protocols across single as well as multiple, co-morbid disease states.

"There is not a common definition ... how do you know we're not integrated?"

– Survey participant

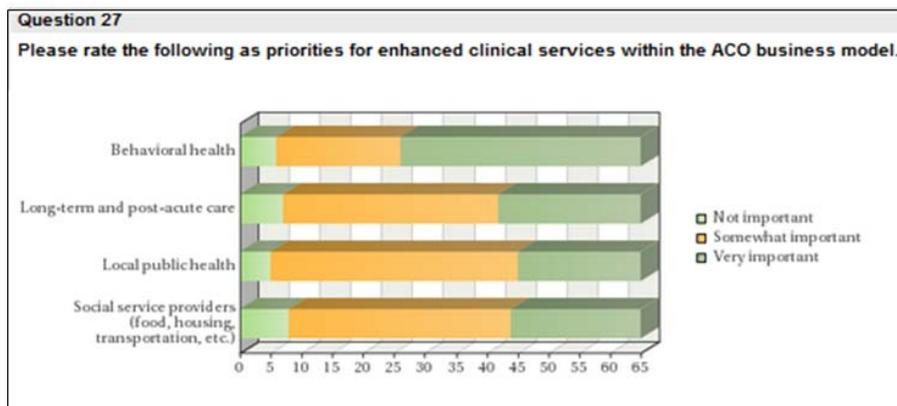
Disease management sophistication varies widely across healthcare organizations in Minnesota. The largest ACOs are significantly more mature than non-ACO organizations, but there is development opportunity for all organizations. The chart below illustrates the relative maturity level of participating providers and health plans' disease management competency, as reflected in their survey responses.



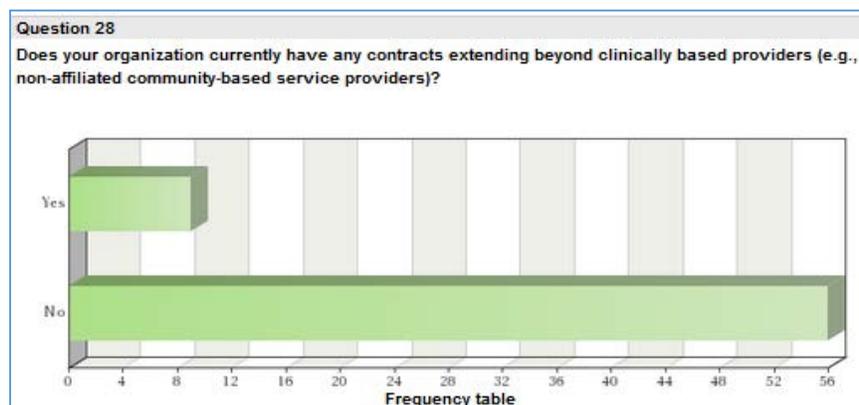
With a median overall maturity in the 10% range, the market consistently identified coordinating care, implementing evidence-based clinical pathways, and managing quality from a program perspective as significant development opportunities. The overall market results are heavily impacted once again by the more than two-thirds of the market reporting little to no ACO business model development (see Table 1). The largest ACO businesses in Minnesota, by comparison, have a competency score of approximately 50%.

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The relative lack of coordinated approaches to disease management are reflected in the detailed survey responses. For example, 60% of provider participants cited the need to develop or include behavioral health as being very important for enhancing clinical services. Better integration with long-term/post-acute care, and public health and social services was also cited.

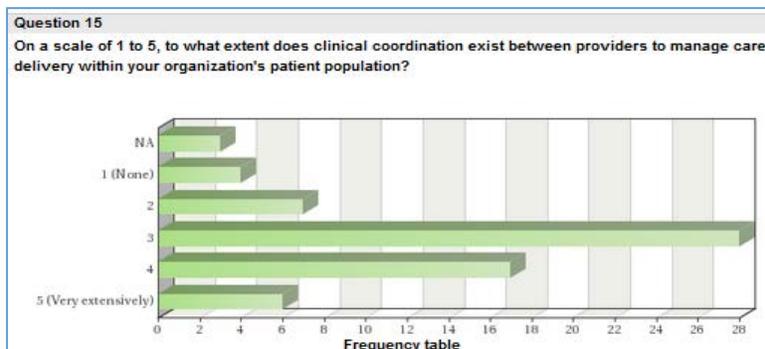


Despite the recognition for the need of these broader services, only 25% of provider participants report a contract extending beyond clinically-based providers to non-affiliated community-based service providers.

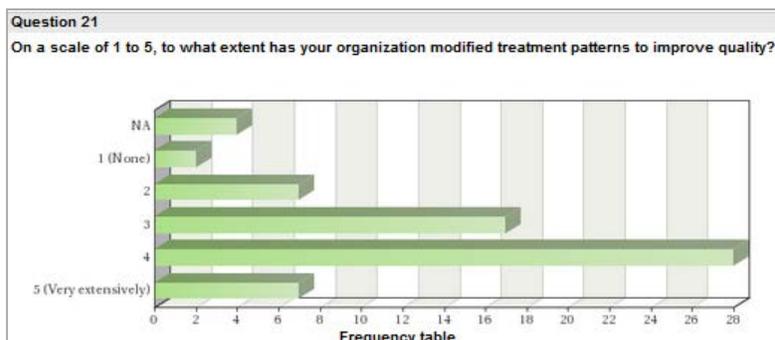


Approximately one-third of provider participants rate the extent of clinical coordination to manage care delivery between providers as extensive or very extensive (4 or 5 out of 5). The majority, though, do not believe this is happening as frequently as it could be (ratings of 3 and lower), as illustrated in the graph below.

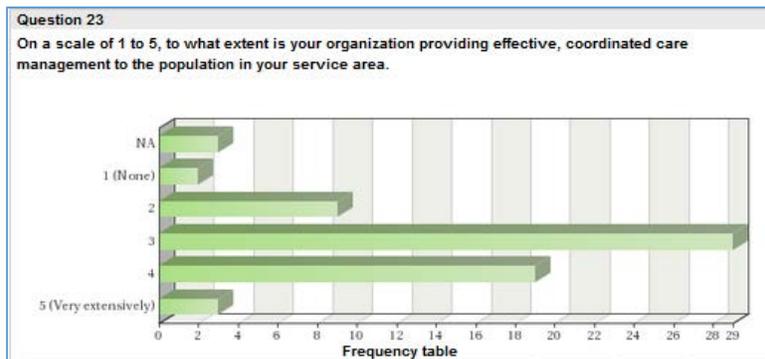
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Despite the relative lack of care coordination and limited development of relationships beyond the clinical, 54% of the provider participants rated the extent to which their organization has modified treatment patterns to improve quality as extensive or very extensive (4 or 5 out of 5).



One-third of provider participants rate the extent to which their organization is providing effective, coordinated care management as extensive/very extensive (4 or 5 out of 5).



Survey participants describe cardiac programs (congestive heart failure, for example) which have been successfully piloted to lower cost and improve quality. One survey participant described the successful and popular use of remote weight monitoring, and

nurse follow-up after discharge, as strategies to mitigate readmission and coordinate care. Care coordination is focused on clinically-based services with limited coordination occurring with non-affiliated, community-based service providers. Very few ACO-based organizations consider non-clinical services within their continuum of care, but still have management perception that they are addressing the needs of the community.

From a quality perspective, initiatives are being implemented to manage for quality, through risk-shared arrangements that are intended to provide incentives to adopt clinical leading practices. An important theme in comments and interviews is that changing disease management and managing utilization does not align with existing, dominant fee for service reimbursement methodologies.

Current programs are in place to identify high-risk patient populations through profiling analytics. A physician 'championship' is described as a leading method to effect physician utilization and manage to best-in-class evidence-based practices. Physicians are looking to receive data-based analytics relative to outcomes specific to their patient population to assist with identifying the changes needed.

In consideration of technology and data analytics, availability and access to real-time data, 'what you need, when you need it' is described as a challenge to delivering more coordinated care. Even if/when 360° view of the patient becomes available within the network, patients do not always stay in-network (described as *lost* as they are potentially referred to different hospitals or providers who may not be in-network).

From an organization perspective, survey participants regularly described the need for consistency. Turnover is experienced within leadership which results in a *stop and start* loss. In addition, care coordination represents a new role, requires new resources, and essentially needs a defined source of funding. Given the demanding role, some participants describe a potential to outsource this work in lieu of staffing internally. In response to some discussion relating to the need for care coordination and incentivizing physicians, and managing the evolution of the clinical path, one participant cited:

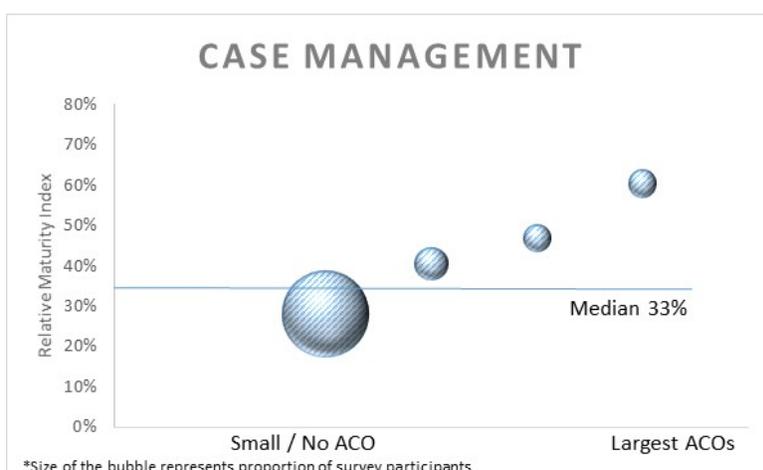
"We expect our healthcare system to not be biased by incentives or reimbursement methodology, but to do the right thing in terms of delivering quality care."

Case Management and Patient Engagement

Based on the CIE Target Operating Model rubric for ACOs, full development of Case Management and Patient Engagement means that the evaluation of disease severity and the management of care continuity is executed through a team-based clinical care delivery model. Furthermore, provider communications, patient education and maintenance of care across the continuum throughout the duration is achieved with continuity, clarity and timeliness. In coordination with population health management, clinical teams overseeing the delivery of care are coordinating with other medical-related consultants and counselors important to the patient (e.g., clergy, social workers, etc.)

“More could be done if we just had the resources... more nurses in the primary care practice, in post-acute care...” – Survey participant

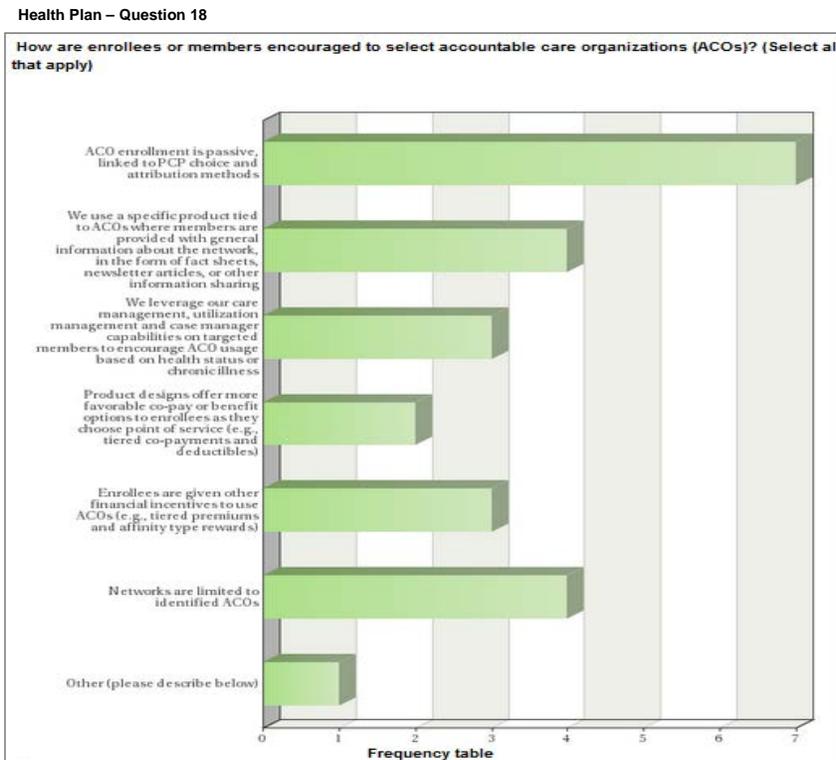
Case management appears to also vary across healthcare organizations in Minnesota. The ACOs with significant enrollment illustrated more development and investment in case management than other survey participants. In general, case management competencies were, on a relative basis, more developed than other competencies, with a median maturity index of approximately 33%. Consistent themes conveyed by all survey participants were an appreciation of next steps relative to transitioning care, patient involvement and reducing readmission rates.



With regard to patient engagement, enrollees are encouraged to select ACOs through multiple strategies, but seven out of eight health plan participants cited passive

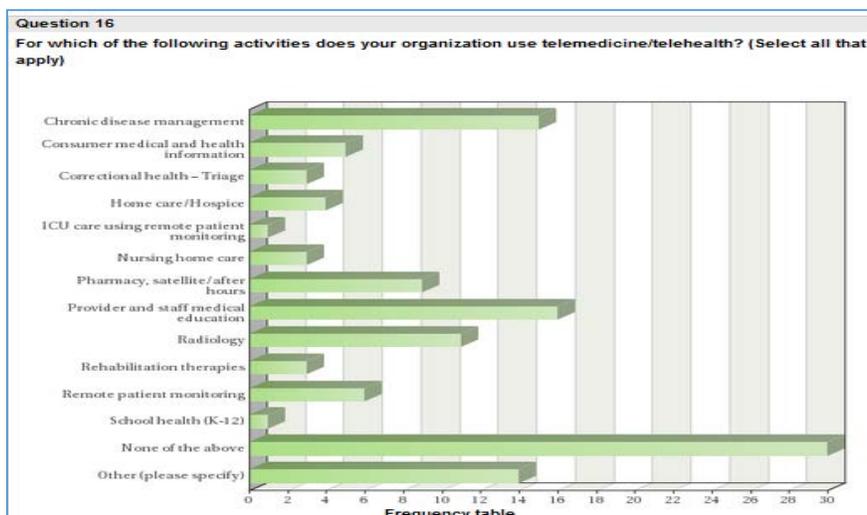
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enrollment, linked to PCP choice and attribution methods, as being the primary enrollment process.



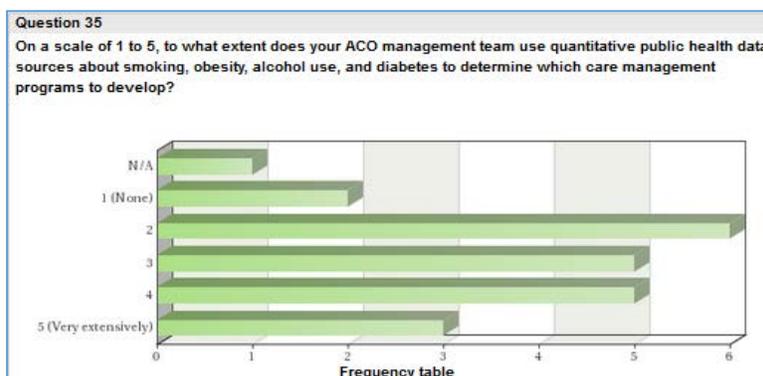
Survey participants felt that telemedicine/tele-health was under-utilized, focusing mostly on case management of chronic diseases, as illustrated in the chart below. Tele-health is seen by many as being an effective tool to foster clinical teaming and timely communication among providers attempting effective case management. Participants indicated that the platform was under-utilized in areas such as education among care givers and education of patients.

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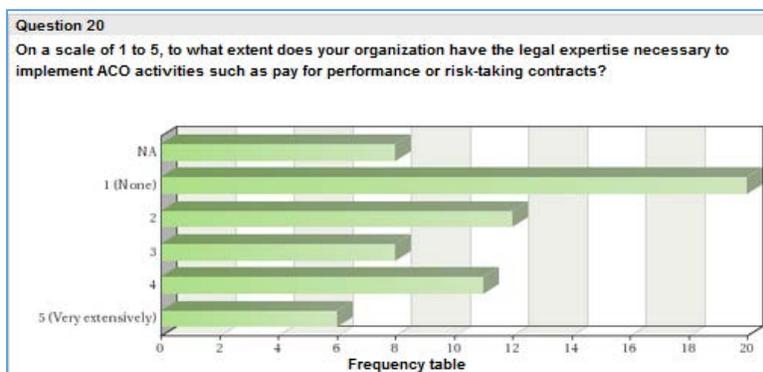
Tele-health is not widely adopted and provider survey participants want more tele-health developed for mental health and specialists. One survey participant described a congestive heart failure (CHF) tele-monitoring program whereby a scale is installed in the home to monitor the patient’s weight.

Of provider survey respondents participating in an ACO, only about one-third report that management uses quantitative public health data sources to determine which care management programs to develop (ratings of 4 or 5 out of 5).

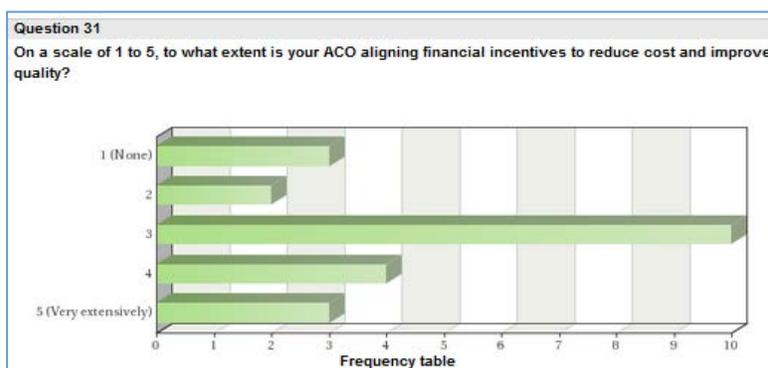


Part of the transformation of care delivery, and getting greater alignment around clinical teaming (e.g., a cross-specialty team representing the various co-morbidities of the patient), case management, and care coordination is the development of risk-based contracting. However, only approximately 25% of provider participants felt that the extent of legal expertise to implement ACO activities within their organization could be considered extensive or very extensive (4 or 5 out of 5).

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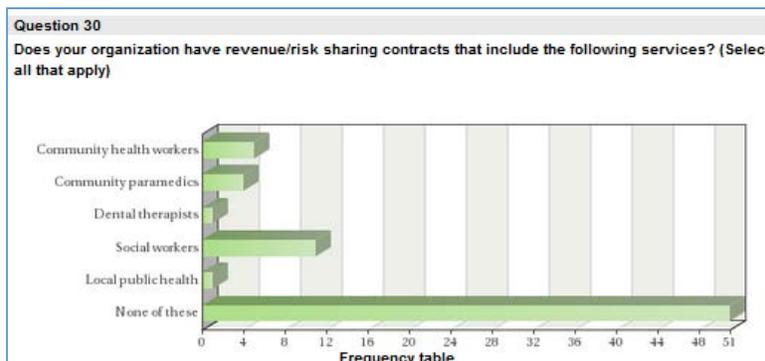
Further, 45% of provider survey respondents participating in an ACO report the alignment of financial incentives to reduce cost and improve quality as average (3 out of 5).



From the survey responses and interview feedback, it appears that care management incentives are not being developed uniformly and do not reflect a consistent (market-wide) movement to at-risk reimbursement. Incentives are only somewhat aligned to encourage collaboration among providers. From survey responses and interview feedback, current risk-shared contracts appear to be focused on upside-only arrangements with minimal current use of downside risk in contracts. For reasons largely explained by risk and complexity, there is some evidence of limited interest by both the provider and payer community to expand risk arrangements. Further complicating the matter, resources and available skillsets continue to represent a challenge as organizations do not have a full competency of legal expertise to implement ACO activities.

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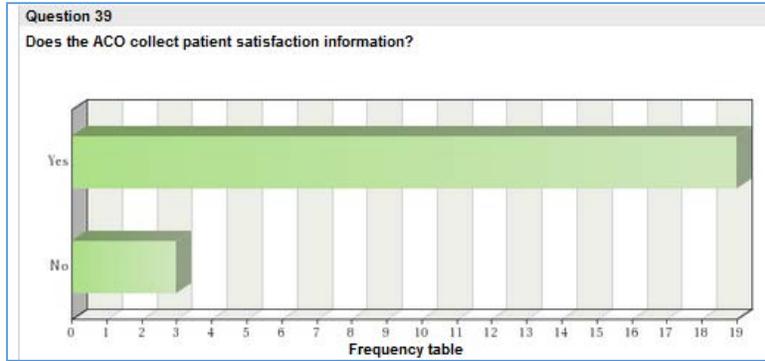
Bringing together some of the previous competencies of population health, case management, and clinical integration and care coordination, it was noted that nearly 25% of provider participants report a risk-sharing contract with care delivery stakeholders that would be classified as non-clinical, with 17% citing contracts with social workers.



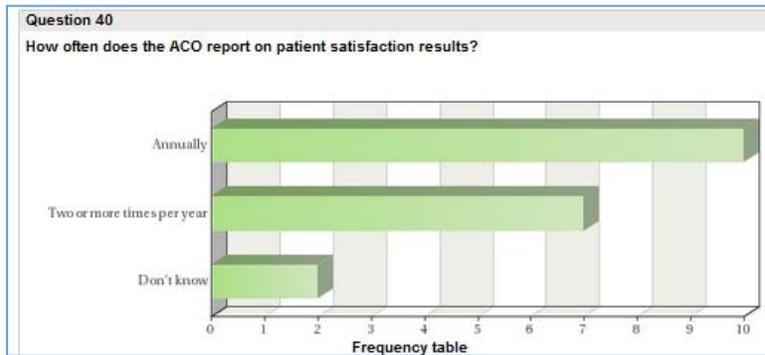
Successes were described in coordinating care through social worker presence in the Emergency Department and 24/7 availability to properly and quickly route care questions to the appropriate place/person (for example, urgent care, specialist, clinic, etc.).

Survey participants report that patient satisfaction was favorable on piloted attempts to address targeted clinical conditions (e.g., congestive heart failure, post-acute care skilled nursing). Telemedicine/telemonitoring is also well received in pilots. In general, participants report that patients are becoming more vocal in their clinical, billing and other interactions, especially with the expansion of high-deductible plans. The opportunity for improved patient satisfaction starts with engagement and gaining appreciation for quality through changing the member experience; participants reflected an understanding that care delivery redesign started with proactively addressing members' needs as opposed to waiting for them to present with an acute condition. Of provider survey respondents participating in an ACO, 86% report that the ACO collects patient satisfaction information.

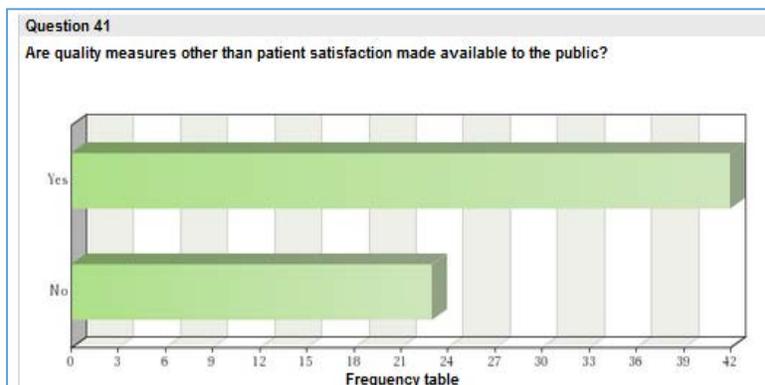
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Of provider survey respondents participating in an ACO and collecting patient satisfaction information, nearly 90% report on patient satisfaction results at least annually.

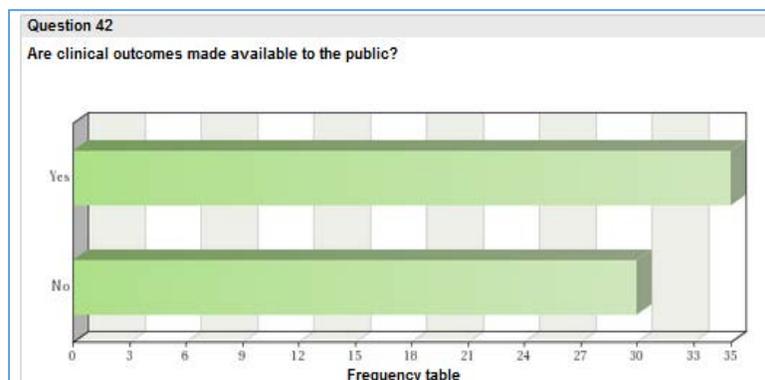


Nearly two-thirds of provider participants report that quality measures other than patient satisfaction are made available to the public.



More than half of provider participants report that clinical outcomes are made available to the public.

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One commonly heard theme from the participants reflected the perceived need for choice within the patient community, which would work counter to narrow networks. There is a perception in the marketplace that patient choice is critical, although there is mixed feedback from survey participants on patient demand for this in practice.

Participants described numerous measures relating to patient education although it remains an area of opportunity, specifically related to usage of the Emergency Department. Active participation in community outreach activities including radio spots, forums, employee assistance programs, newsletters, and online, internet streaming video service hosting sites were enthusiastically cited by the participants. Higher patient engagement was experienced in areas with an assigned 'point person' to handle communication. Increased interaction with the patient does result in positive satisfaction scores, but not necessarily return on investment. From a communication perspective, although patient satisfaction and quality reporting is communicated to the public, clinical outcomes are not.

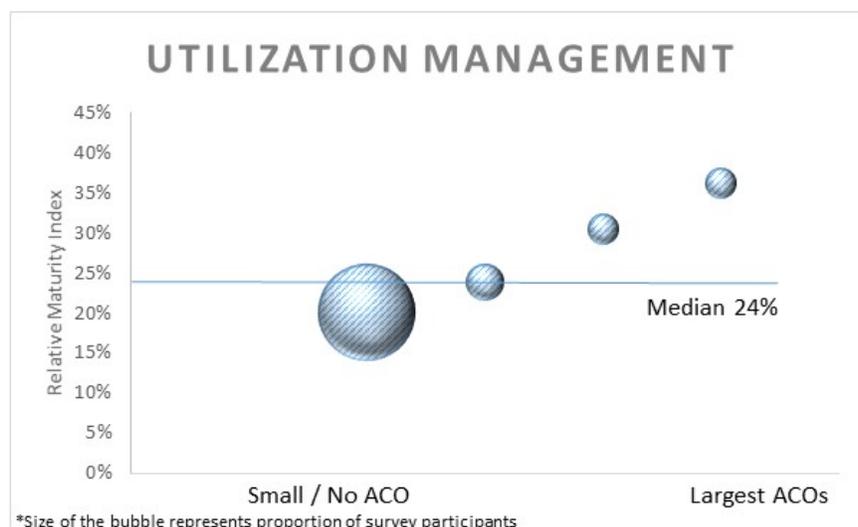
Lastly, survey participants noted that case management could be better optimized with data-driven outcome analytics, but that meaningful, timely, accessible data representative of the patient population is not always readily available to drive care management program development. Further, participants noted that there was a practical need to educate broadly on the diagnoses and procedural coding for bundled payments. Participants are concerned about the awareness of what changes in the methodology will be needed as driven off the transition from ICD-9 to ICD-10 coding.

Utilization Management

Based on the CIE Target Operating Model rubric for ACOs, full development of Utilization Management means that there is a purposeful and cultural focus on reducing waste and duplication in care delivery processes, supported by a professional review and use of guidelines to enforce established clinical practice and maintain efficient resource management.

Utilization management appears to have a moderate and consistent level of development across Minnesota. There was little to no variation between the largest and smallest ACOs for this competency.

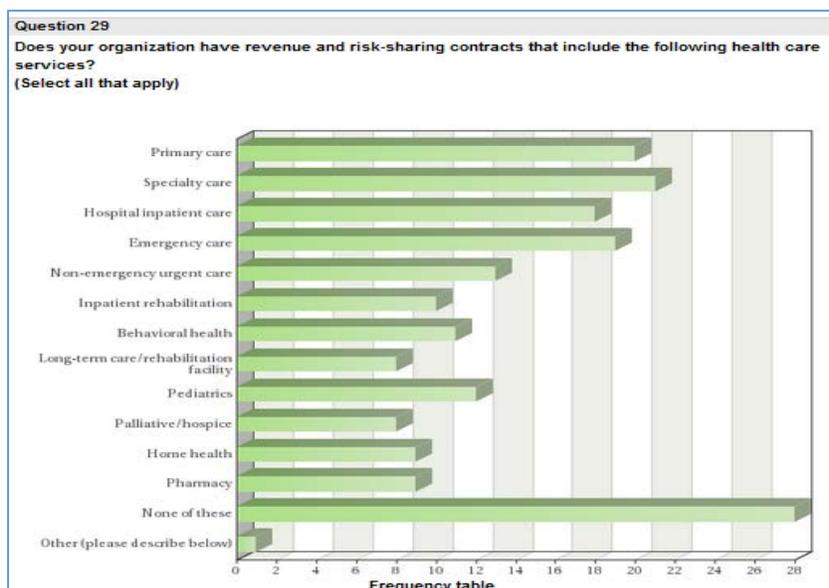
Through interview feedback, there was evidence of a cultural resistance to change. The shift from volume to value challenges the traditional notion of keeping beds filled. Within Minnesota, the survey results indicate a median relative maturity of approximately 24% in utilization management capabilities. Participants acknowledge a need to better analyze current and future expected utilization, and to better understand the cost/savings dynamic associated with intensity of services and site of care shifts. There was also acknowledgment that peer review was needed in order to establish the definition of clinical protocols and evidence-based medicine.



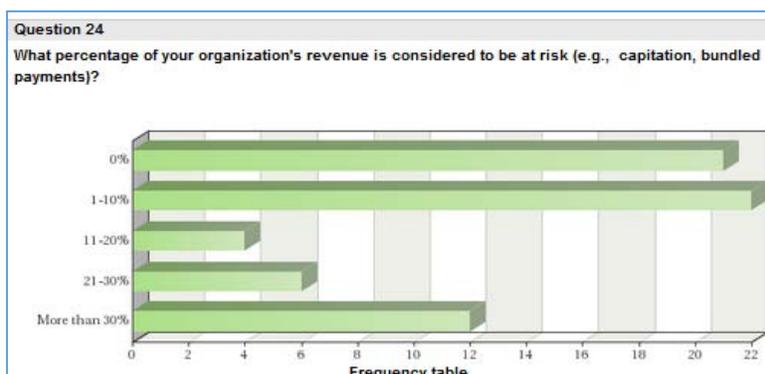
Remembering that the current reimbursement methodology is largely still utilization-driven, migrating away from a utilization-driven reimbursement methodology will impact the provider community, hospitals in particular. Provider respondents appear to be

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reluctant to embrace a revised reimbursement methodology which may not equally share risk and will not provide a solution for capacity (e.g., empty beds). Where these relationships are in place, networking relationships and integrated care appear to be limited to the medical community, specifically focusing on specialists, primary care and hospitals. There are a minimal number of unaligned, primary care practices. The movement to maturity is predicated on executive leadership reflecting the commitment to integrated care models, with all of its potential reimbursement risk, encouraging participation across the care delivery network. Participants report a wide variety of healthcare services covered under a risk-sharing contract, with primary, specialty, hospital and emergency care leading the list.

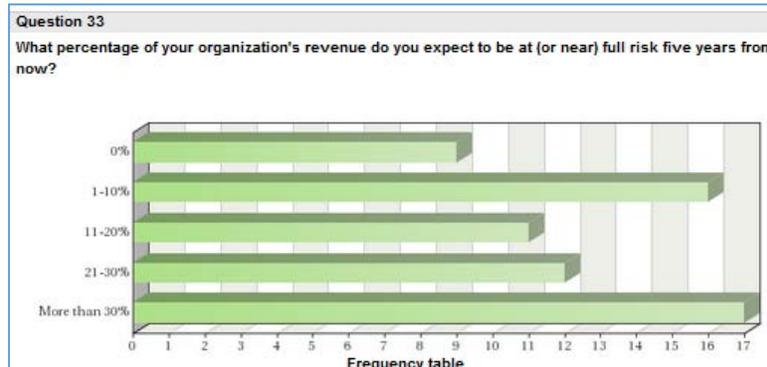


Two-thirds of provider participants report the percentage of revenue which is considered to be at risk at 10% or less.

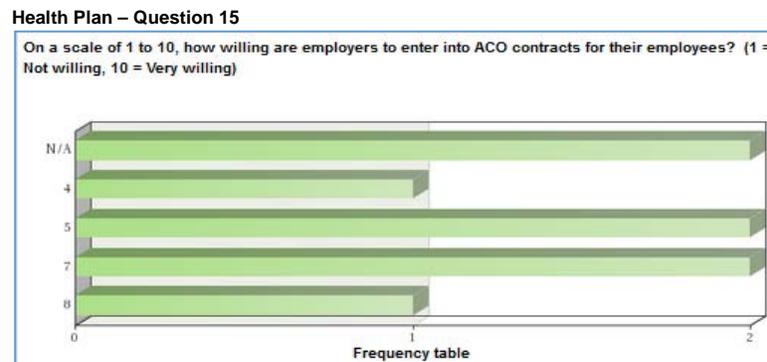


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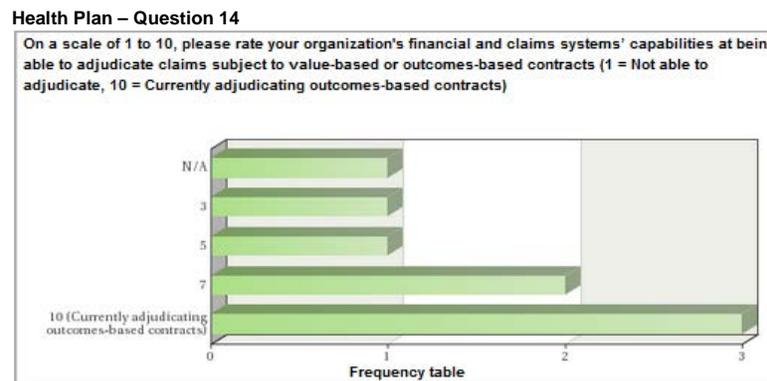
Five years from now, more than 25% of the provider survey participants expect more than 30% of the organization's revenue to be at (or near) full risk.



Six out of eight health plan participants rated employers willingness to enter into ACO contracts for their employees between 5 and 8 (based on a scale of 1 to 10, 10 representing most willing).



Five out of eight health plan participants rated their capability to adjudicate claims subject to value-based/outcomes-based contracts as 7 or higher, based on a scale of 1 to 10, 10 representing most proficient, currently adjudicating.



Risk-based arrangements are largely described as ‘one way’. A minimal number of contracts are described as incorporating downside risk such that the provider would receive less than utilization-driven reimbursement. In addition, there is evidence of a growing movement of ASO (administrative services only) by the employer community and resistance by the employer community to buy into value-based reporting.

Although consistent activity is described relative to the identification of at-risk patients and closely monitoring their utilization, a clinical path, or a 360° view of the patient, is not readily available for the purpose of managing downstream risk and total cost of care. One participant noted that real change in utilization management will be experienced when considering a holistic approach to the patient, considering what may be prompting the initial call to the ambulance in the first place. Participants noted that integrated care introduces additional roles not previously needed to manage utilization and address practice patterns, but that existing personnel do not have capacity for this expanded work, and the return on investment is unclear for these roles.

Participants mentioned that successful risk-based arrangements would be predicated on transparent communications, data and methodology. Coincidentally, nearly every survey participant discussed the process of developing trust across the continuum of healthcare stakeholders, and that the successful implementation of optimal clinical paths would only be built on qualified, trusted data and analytics.

Although survey participants had varying opinions regarding incentivizing behavior, and even if incentives were necessary, it was acknowledged that long-term reimbursement impact cannot be associated with short-term behavior change. As summarized by one survey participant:

“If we want to affect change in day to day behavior, then we need to change the day to day payment mode.”

Clinical Decision Support

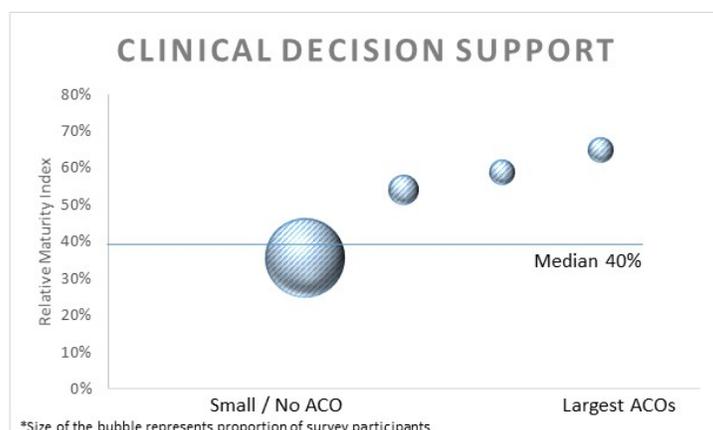
Based on the CIE Target Operating Model rubric for ACOs, full development of Clinical Decision Support means analyzing care delivery, utilization and efficiency against benchmarks and evidence-based protocols that support patient care needs and diagnostic decision-making as well as supports analysis of cost-effectiveness and financial performance.

Clinical decision support appears to be one area of great focus across all healthcare organizations in Minnesota. The largest ACOs appear to have been able to invest and develop in evidence-based standards, benchmark development, and provider efficiency and outcomes analytics more than the rest of the market.

As stated by one survey participant in describing the challenges relating to performing outcome analytics based on a 360° view of the patient:

“Who is going to own evidence-based outcome analytics?” – Survey participant

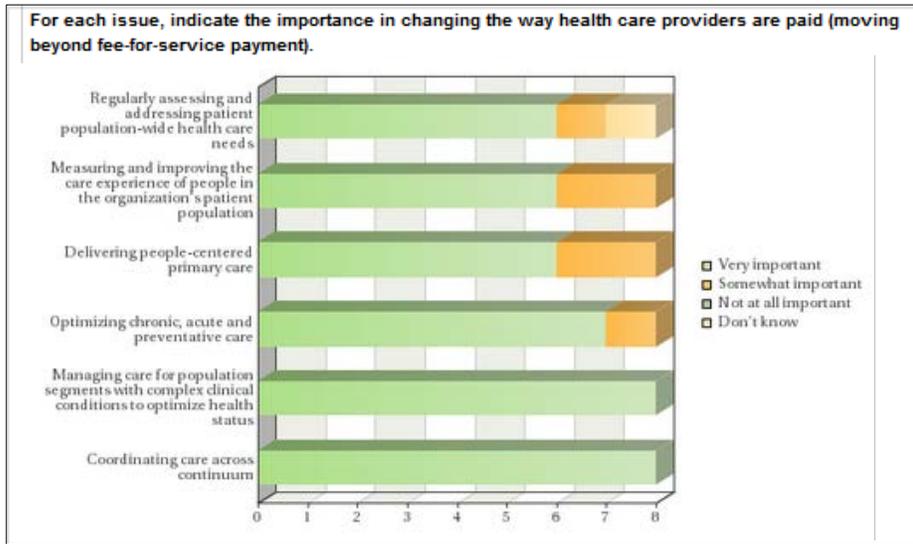
Survey responses for clinical decision support illustrated a fair degree of competency development, with a median rating of 40%, as illustrated in the chart below. Developing evidence-based standards, managing cost and programmatically implementing follow-up services through a programmatic approach were cited as important development opportunities.



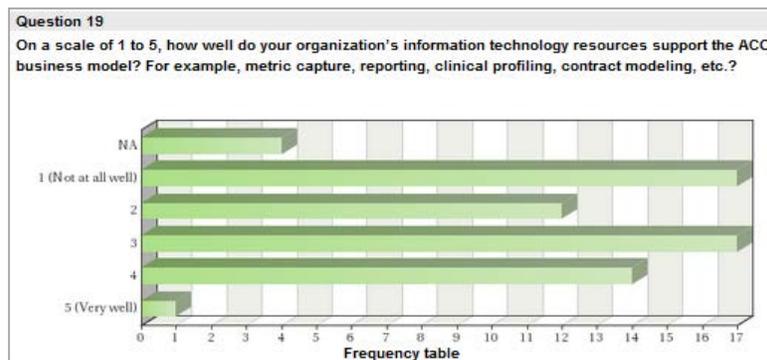
Participants cited managing/coordinating care as a very important issue in changing the way healthcare providers are paid, moving beyond FFS payment.

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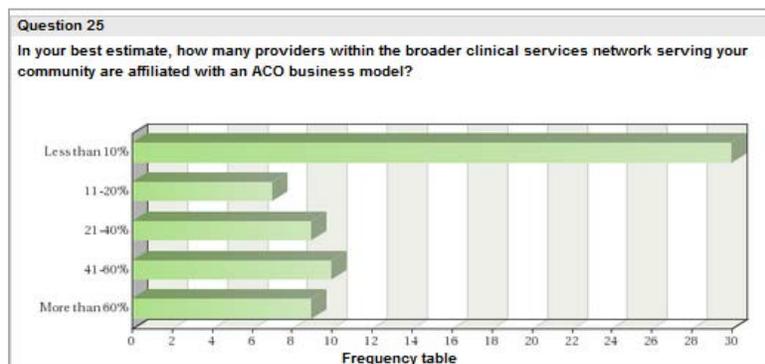
Health Plan – Question 19



Provider survey participants report significant variation in how well the organization's information technology resources support the ACO business model.



Fifty-six percent of provider participants estimate that less than 10% of providers within the broader clinical services network are affiliated with an ACO business model.



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Nearly two-thirds of provider participants separately cited staffing, infrastructure, information technology, and training and education as needed to achieve clinical integration.



Demonstrating signs of increasing maturity, survey participants shared evidence of a growing physician voice looking for best practices based on relevant data analytics, as opposed to relying solely on experience and institutionalized best practices.

Participants noted that the successful implementation of evidence-based standards has occurred with the use of qualified, trusted data and a physician champion. With these leveraged assets, participants cited success in achieving a more optimal clinical path with broader practitioner acceptance. Some successes were reported in pilots relating to radiology orders or ED utilization, but broader evidence of managing clinical protocols was largely limited to identifying high-risk patients and managing pharmacy-type usage (brand vs. generic drug ordering).

To drive these evidence-based standards, data accessibility, with a 360° view of the patient experience, is an issue. Datasets are largely limited to medical visits related to treatment of an acute condition. Expanding this same issue across a patient population, challenges are reported in analytic strategy, evaluating and deriving optimal outcomes, and the identification of best practices. Additional challenges are experienced in resource availability, both in executing defined criteria and in translating business criteria into technical programs and performing 'what-if' scenarios which often represent complex analyses. Even if available, the ability to view all available services may be impacted by participation in the ACO and/or representing a clinically-integrated entity.

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Interestingly enough, competition is largely seen on the execution of a clinical pathway, but not on its definition. The idea of an outsourced entity to facilitate and drive evidenced-based standards for the purpose of defining clinical protocols was discussed at some length with multiple interviewees and represents a consideration for the industry. To that end, and given the rate of change within the industry, transformational analytics are needed in lieu of traditional reporting practices.

Performance Management

Based on the CIE Target Operating Model rubric for ACOs, full development of Performance Management means beyond timely and accurate financial performance metrics and dashboards, there are consistent and timely public reporting of operational performance on a clinical and quality-related basis reflecting patient experience, practice performance and progress against population health-based initiatives.

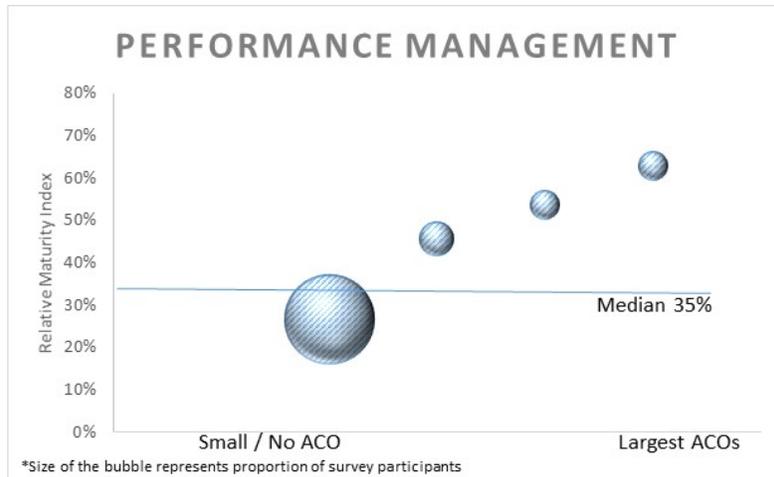
Performance management and analysis of patient experience measures appears to vary widely across healthcare organizations in Minnesota. The largest ACOs accept transparency around triple aim goals and performance, and have more capabilities related to reporting on these metrics than smaller and/or non-ACO organizations.

Describing the permanent change from a utilization-driven reimbursement system, one participant put it this way:

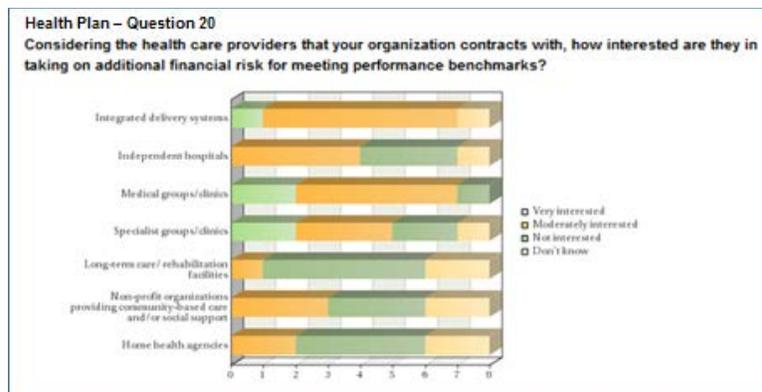
"We may never get back revenue that is lost ..."

Performance management relates not only to supporting finance, but providing support to management and clinical services professionals across the continuum of care under the ACO business model. Survey participants described additional work needed in the areas of practice management reporting and public reporting. The chart, below, summarizes the survey results. The relative development of performance analysis capabilities appears to be about 40% in aggregate, but there is disparity between the smallest organizations and the largest. Smaller organizations in the survey only had 20% development of this capability versus 60% for the largest.

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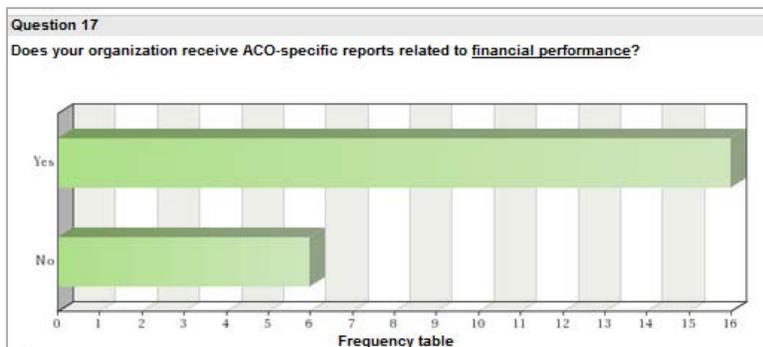
Two out of eight health plan survey participants cited medical groups and specialist groups as being very interested in taking on additional financial risk related to outcomes performance benchmarks.



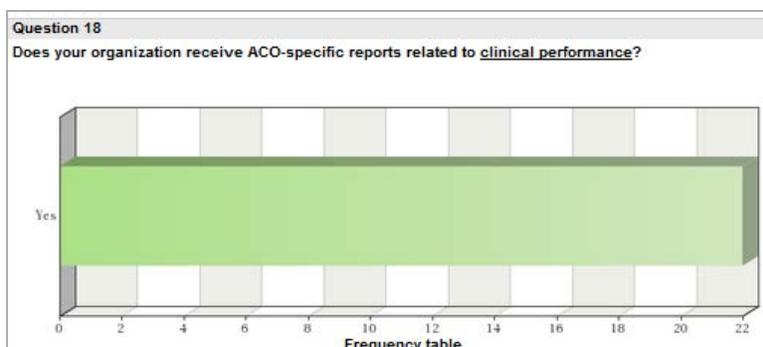
Hospitals, long-term care providers and home health agencies note that shared risk is not evenly distributed among the various providers. Therefore, alternative payment arrangements need to reflect the role of the individual provider in the final outcome.

Of provider survey respondents participating in an ACO, nearly 75% receive ACO-specific reports related to financial performance.

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Of provider survey respondents participating in an ACO, 100% receive ACO-specific reports related to clinical performance.



Current reporting includes clinical outcomes, but feedback is mixed on the level of financial impact reporting provided. It was unclear in some cases whether the inability was a function of technical capability related to claims pricing capabilities. Similarly, outcomes-based analytics require diagnosis-level/HCPCS codes; data that is shared among the network does not necessarily have the level of data required for analytics. It was unclear as to whether this lack of data reflected technical limitations related to the file layout, lack of appreciation of the importance of HCPCS/diagnosis codes, or related to underlying issues in generating episodic information/bundled claims.

Participants regularly cited data accessibility and software functionality as impeding advancements in ACO maturity. Some participants noted that software modules do not necessarily contain all of the care delivery functionality needed. Several interviewees described the need to develop specific functionality with the vendor to meet business requirements related to coordinated care. A robust health information exchange with data reflecting a 360° view of the patient is needed to generate analytics related to

outcomes and performance. Data security and privacy concerns, and federal laws (e.g., HIPAA), were also mentioned as critical concerns.

Calculation of a 'bundled payment' may represent administrative and financial obstacles due to the timing of different claims by different billing entities and/or providers. Further complicating the process, bundled payments are particularly dependent on the billing diagnosis/HCPCS to accurately identify an *episode*.

One additional point to consider, raised in an interview, is where the accountability for *change* really sits. For their organization, they are focused on the individual employee to initiate change, and incorporates the employee's ability to demonstrate clinical integration with other departments as part of their annual performance review process. Performance management by another name, but, by their account, just as effective.

Conclusion

This inaugural survey applies a competency-based approach to evaluate the Minnesota market and its on-going transformation toward accountable care, driven by quality and performance-based incentives that achieve lower overall costs and maintain or improve access to care. There appears to have been investment and development of ACO-related capabilities in this regard, but, at the same time, it is noted that more development is needed to address the goals of the triple aim.

Subsequent development surveys will look to refine the questions, get broader participation, and track the progress of the market in its development.