

Minnesota Accountable Health Model: State Innovation Model (SIM) Grant – DRAFT 8/28/13

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 by providing investments in infrastructure and directly to providers and communities that will participate in ACO/TCOC models under a framework of accountable care and payment, including the Health Care Delivery Systems (HCDS) demonstration as a foundation, that aim to: coordinate and integrate care and service delivery across the continuum; improve quality, patient experience and health outcomes; 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**

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

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

Care Delivery and Payment Transformation

- There are identifiable small and rural providers participating in ACOs or other Total Cost of Care arrangements) *without* merger, consolidation etc.
- 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 and long-term care service and supports.
- The state in collaboration with payers, providers, and community has defined base requirements and structure (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 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 providers participating in, or preparing to participate in, ACO/TCOC models occurs in a more seamless/real time way across settings (clinic/hospital/LTC/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 ACO/TCOC 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, with specific

roadmaps for behavioral health, long-term care, and social service providers and a focus on key transactions needed to support evolving ACO-type or coordinated care models.

Care Delivery and Payment Transformation

- Resources, assistance and support are available for providers and communities to participate in ACO/ TCOC through integrated care models (e.g. primary care/HCH/behavioral health home, behavioral health, long-term 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 population health goals and targeted to achieve cost savings for Medicaid and other payers.
- Providers 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

- A minimum of one to two ACO/ACHs have a model that integrates services and providers in behavioral health 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

- ACOs are beginning to establish robust working partnerships with community-based organizations 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 an ACO/TCOC care delivery and payment model.

Community partnership

- We have created new, sustainable venues through which providers engage with communities in more meaningful ways to improve individual and community/population health – with accountability on both sides. This will be achieved

through true partnership, not through new mandates.

- Participating ACH communities have partnered with stakeholders and community members throughout the development and implementation of their community plans.

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 ACO/TCOC 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
- Support broad infrastructure investments as well as community/model/provider specific investments
- Leverage existing programs, infrastructure and investments wherever possible
- Pair with policy and state law changes or additional federal approval

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

- Potential to be replicated/expanded
- A strong and realistic sustainability plan
- Return on Investment (ROI) – savings to Medicaid, Medicare, and private payers
- Specific goals/outcomes/evaluation that are clear and well designed, and aligned with statewide goals for population health improvement and disparity reduction
- Multi-payer support and commitment
- Strong and collaborative relationships between providers, payers, community/patients/consumers, employers, and other stakeholders in the design and implementation of activities
- Participation in HCDS or other ACO/TCOC payment models or in preparation of/building toward participation in these models