Minnesota
Health Care Financing Task Force

HEALTH CARE DELIVERY DESIGN & SUSTAINABILITY

DECEMBER 18, 2015

MINNESOTA
HEALTH CARE
FINANCING
TASK FORCE

Health Care Delivery Design & Sustainability

December 18th 2015

Agenda

- Welcome, Roll Call, and Meeting Purpose
- Review of Voting Process
- Modeling Results
- Enhancements that Support Integrated Care Delivery
  - Review proposal package
    - Short-term
    - Long-term
- Public Comment
- Next Steps, Next Meeting and Wrap Up

Review of Voting Process
The Path to Final Recommendations

Step 1: Workgroup Responds to Survey about Recommendations (Dec. 18-23)

- Based on a Likert Scale; need 51% of possible points to be included in the recommendations package.
- Results will be made available to Members on ~Jan. 4 (and to the public online).

Step 2: Manatt Drafts Package with Input from Workgroup Leads (Dec. 28-Jan. 4)

- Package will identify where there were differing views among members.
- Members will receive a preview of package ~Jan. 4

Step 3: Workgroup Amends, as needed, and Votes on Package (Jan. 8)

- Package presented to Workgroup on Jan. 8th for discussion and amendments.
- Vote to approve means there is agreement with most (but not necessarily all) of the recommendations.
- Majority vote needed to approve package to be sent to the Task Force.
- Amendments require supermajority (3/5) for approval; no new items may be added by amendment.

Step 4: Task Force Amends, as needed, and Votes on Package (Jan. 15)

- Package presented at Task Force on Jan. 15 for discussion and amendments.
- Vote to approve means there is agreement with most (but not necessarily all) of the recommendations.
- Amendments require supermajority (3/5) for approval; no new items may be added by amendment.

Modeling Results- Data Sources

- Detailed **encounter data and enrollment records** (PMAP & MinnesotaCare for CY 2012 to 2014)
- **Analysis of capitation rate development** related to benefit differences between PMAP and MinnesotaCare (2014 to 2016)
- **Risk scores** for PMAP and MinnesotaCare populations (2014)
- PMAP and MinnesotaCare health plan **competitive bidding results** (2016)
- **Integrated Health Partnership (IHP)** risk-share calculations (2014 & 2015)
- Milliman **Health Cost Guidelines – Dental** (2015)
- MN Health Access Survey & Federal American Community Survey (2013) for **uninsured and individual market**
- **Health plan enrollment, claim costs and premiums** from 2014 Small Group and Individual Market Survey (by metal level, age/rating region levels)
- Summaries of 2015 **enrollment, premiums, premium tax credits (APTC) and cost sharing reduction (CSR)** for On-Exchange and Off-Exchange plans
- **Estimates for program-wide enrollment** for On-Exchange and Off-Exchange individual plans and percentages of On-Exchange eligible for subsidies (2014-2016)
- DHS estimates of **family glitch impact** by type of coverage
- 2016 Filed health plan Individual Market **Unified Rate Review Templates (URRTs)**

Options Modeled

Changes to Provider Payments –

- Enhancements to risk-based provider contracting and monthly prospective care management payments:
  - ACO arrangement with retrospective shared savings for attributed population (prospective "pre-payment" tied to retrospective savings measurement) (similar to IHP)
  - For enrolled population not in ACO arrangements, monthly prospective care management payments without retrospective shared savings (similar to HCH)
- These enhancements were applied to the following populations:
  - Prepaid Medical Assistance Program (PMAP)
  - MinnesotaCare (MNCare)
  - On-exchange individual market plans (QHP)

Option: Changes to Provider Payment Mechanisms

Key Assumptions (1/2)

- Enhancements to models result in increased participation. Penetration rates included:
  - QHP: 45% ACO/IHP; 45% HCH; 10% none
  - MNCare: 45% ACO/IHP; 40% HCH; 15% none
  - PMAP: 45% ACO/IHP; 40% HCH; 15% none
- Number of members included:
  - ACO/IHP: 395,000
  - HCH: 354,000
  - Not attached to either: 128,608

Option: Changes to Provider Payment Mechanisms

Key Assumptions (2/2)

- Tiers for monthly prospective payment built on current HCH, adding a "Tier 0":
  - Tier 0 - $2
  - Tier 1 - $10.90
  - Tier 2 - $21.30
  - Tier 3 - $40.41
  - Tier 4 - $59.80
- Costs (savings) are based on a single year's experience of a fully implemented program; it does not account for program "ramp up"

Option: Changes to Provider Payment Mechanisms

Total Costs (Savings)

Total (State and Federal) Cost Impact	
PMPM	$ (in Millions)
($4.57)	($48.1)

Option: Changes to Provider Payment Mechanisms

Financing Mechanisms

Program Segment	State (in Mill.)	Feds (in Mill.)
QHP; IHP/ACO program	$0.0	($3.7)
QHP; HCH-like program	$0.0	($0.6)
MNCare; IHP/ACO program	($5.1)	$0.0
MNCare; HCH-like program	($1.1)	$0.0
PMAP; IHP/ACO program	($9.5)	($21.3)
PMAP; HCH-like program	($2.1)	($4.7)
Total	*($17.8)*	*($30.3)*

Option: Changes to Provider Payment Mechanisms

Key Drivers

For both arrangements -

- Increased provider uptake due to more attractive arrangements
- Financial support of care coordination efforts results in a net savings
- Savings assume programs are at full operation (i.e. “ramp up” has already occurred)

Integrated Care Delivery Enhancements Proposal Package - Cross-cutting

- **Ongoing evaluation** of current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals.
- **Enhancements incorporated into existing programs** (e.g. IHP, HCH, BHH, etc.). Any new arrangements to be considered pilots, with expansion across full population only with robust evaluation.
- **Seek alignment of approaches across public and private payers**, IBNLT consistent measurement and payment methodologies, attribution models, and definitions.

Integrated Care Delivery Enhancements

Proposal Package – Immediate Enhancements (1/4)

Community partnerships

- Encourage or incentivize partnerships and care coordination activities with **broad range of community organizations** within care coordination models.
- Fund **innovative grants and contracts** to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.

Health disparities and health equity

- Encourage or incentivize **participation of diverse patients** in provider or provider/community collaborative leadership or advisory teams.

Integrated Care Delivery Enhancements

Proposal Package – Immediate Enhancements (2/4)

Measurement (for public reporting or payment)

- Measurement (quality and cost) should be based on the following principles:
  - Measures include **risk adjustment methodology that reflects medical and social complexity**.
  - Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both **performance vs. provider's previous year and performance vs. peer group**, to incentivize both lower and higher performing, efficient providers.
- **Incorporate system wide utilization measures** to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.

Integrated Care Delivery Enhancements

Proposal Package – Immediate Enhancements (3/4)

Payment

- For participants not attributed to an ACO (such as IHP program), provide a **prospective, flexible payment for care coordination, non-medical services and infrastructure development** that is sufficient to cover costs for patients with complex medical and non-medical needs.
- For participants attributed to an ACO (including IHP program), provide a **prospective "pre-payment" of a portion of their anticipated TCOC savings**.
- Establish **consistency of payment approach** for care coordination and alternate payment arrangements across all payers. Areas for consistency include (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.
- Ensure that **tiering and billing processes** do not pose a barrier to reimbursement, and **payment is sufficient** for patients with complex medical and non-medical needs and for needed infrastructure and workforce changes to support team-based, coordinated care.

Integrated Care Delivery Enhancements

Proposal Package – Immediate Enhancements (4/4)

Attribution and patient selection of provider

- Patients will **choose a provider during the enrollment** process. Method should be **consistent across payers**.
- When patients are attributed or assigned to a primary care provider or care network for the purposes of payment (not for care delivery), attribution should be prospective, with back-end reconciliation.

Integrated Care Delivery Enhancements Proposal Package – Longer-term impact

Study long-term payment options for health care delivery.

- Study will evaluate impact on cost and quality of health care system, stability and sustainability of system, and data/informational needs to design and implement the system.
- Study to include, at a minimum, comparison of the following approaches:
  1. Maintenance of **current financing mechanism**, without expansion of value-based purchasing beyond existing levels
  2. **Expansion of value-based purchasing** within current system
  3. **Direct contracting** with providers, including Primary Care Case Management, through a full or partial risk capitation payment
  4. Publicly-financed, privately-delivered **universal health care system**

Integrated Care Delivery Enhancements Additional Long-Term Concerns

- Identify ways of enhancing existing payment models to more comprehensively include the **dual eligible population**
- Identify methods to report on the **costs and savings associated with non-medical services**, with potential integration into TCOC calculations
- **Prescription drug costs outpacing medical inflation**, and potentially hindering overall savings efforts
- **Growth of long-term care costs**; how do we manage these costs and make them sustainable as population grows older?
- **Workforce shortages**, particularly in the areas of primary care and mental health practitioners

Next Meetings

Task Force
Friday, December 18th, 2015, Noon to 3 pm
Eagan Community Center
1501 Central Parkway
Eagan, MN 55121

Workgroup - Recommended Package Voting
Friday, January 8th, 2016, 9 am to ??
Anderson Building, Room 2390
540 Cedar St., St. Paul, MN
Conference Line: (888) 742-5095, Code: 796-395-9269