



Aligning Incentives in Medicaid

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Health Care Payment and Delivery Reform in Minnesota Medicaid

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Abstract: Minnesota's Medicaid program is a leader in piloting innovative health care payment and delivery reforms. New in 2013, accountable care organizations (ACOs) have entered into shared savings and risk agreements with Medicaid. State officials believe that ACOs will give providers greater incentives to promote population health and integrate care than do traditional managed care organizations. Minnesota has sought to align the goals, measures, and incentives for this program with other state initiatives and hopes to do so with Medicare and commercial insurers in the future. In addition, Minnesota has just been awarded a State Innovation Models Initiative grant that will make the accountable health care model available to all citizens. This case study is one of three in a series on innovations being undertaken by states to improve quality and efficiency in their Medicaid programs.



OVERVIEW

For many years, Minnesota has been held up as a model for health system reform. The state's current activities are again noteworthy for seeking innovative ways to achieve the goals of lowering health care costs and improving quality. Among the new programs under way, the one with perhaps the greatest potential to transform the health care system is the introduction of accountable care organizations (ACOs). The new ACOs will enter into shared savings and risk arrangements with the state Medicaid agency to achieve better health outcomes while being accountable for the total cost of care for their patient population.

Medicaid officials believe ACOs may give providers greater incentives to make changes in care delivery to keep people healthy than do traditional managed care organizations. They also see ACOs as better able to integrate care across settings. Minnesota launched its accountable care program starting first with an organization of safety-net providers in Hennepin County, which began enrolling low-income, childless adults in January 2012. Separately, the state solicited bids from throughout the state to participate in a Medicaid ACO

demonstration. Six other accountable care organizations became operational in January 2013 and three more are negotiating with Minnesota Medicaid to start later this year. They will serve an initial enrolled population of approximately 100,000 Medicaid beneficiaries. Although the participants include several integrated systems with experience in care coordination, these organizations may have to tailor their services to the needs of Medicaid patients, conduct performance measurement and improvement, or introduce new cost-management activities to meet Medicaid standards. The state also is considering a similar ACO program for beneficiaries of both the Medicare and Medicaid programs, known as “dual eligibles.” And in February 2013, CMS awarded Minnesota a State Innovations Model Initiative grant to test and implement an accountable care model for the entire state. The “Accountable Communities for Health” initiative will create linkages among the ACOs, Medicare, and commercial insurers to promote care coordination and access to a wide range of acute, behavioral, long-term care, public health, and social services.

Drivers of Reform

The key drivers of reform in Minnesota are:

- a culture of strong leaders in and out of government who seek to improve health care;
- a keen awareness of the limitations of previously attempted reforms to provide the cost savings and other changes needed;
- the pressure of rising costs and the need to rein in the Medicaid budget; and
- the presence of many integrated delivery systems in the state—of which many are in a position to integrate inpatient and outpatient care and take on risk, and already have begun implementing innovative models of care delivery.

Lessons

Minnesota’s experience in promoting accountable care offers the following lessons:

- States can promote systemwide transformation by aligning goals, measures, and incentives across Medicaid initiatives, state programs, and with Medicare and commercial insurers.
 - Minnesota’s reforms have much in common with federal reforms in their intention to make care patient-focused, accountable, and cost-effective.
 - Different state programs build upon each other and pursue common outcomes. For example, Minnesota’s multipayer health homes program certifies health homes, which are a required component of its new Medicaid ACOs.
 - Some of the state’s reform initiatives include the state purchasing agency for public employees and private-sector purchasers.
 - Medicaid is seeking to align its efforts with Medicare through a planned ACO demonstration program for dual eligibles.
- States can encourage providers to develop certain parameters for the organization and delivery of coordinated care.
 - Minnesota gives applicants considerable flexibility in forming their ACOs. Still, the state provides specific requirements for ACOs, based on 18 months of work by a stakeholder group.

- States can remove silos in the health care system by bringing together all of the providers that serve a population and giving them incentives to collaborate.
 - Hennepin Health, a safety-net ACO that will serve up to 10,000 low-income, childless adults this year, brings together physical, mental, and dental health providers along with social support services, including transportation and housing. Further, coordination with the corrections department will promote seamless transitions in health care for people leaving prison.
- When states invest in measurement and reporting, it is possible to apply the lessons of past work in designing new reforms.
 - Minnesota has many resources in this regard, including an all-payer database, dedicated funds for analysis by university-based researchers, and a stakeholder group identifying standards for the quality of care.

Opportunities for Federal Action to Support State Efforts

Minnesota has benefitted from leadership by the Centers for Medicare and Medicaid Services (CMS) in promoting reforms that can help the state meet its goals for higher quality, lower costs, and improved access. Going forward, Minnesota will want to partner with CMS in implementing new payment strategies. In particular, its reforms will require that the state Medicaid agency have the ability to pay for health outcomes, rather than services. This may mean allowing care managers to offer services that fall outside the traditional purview of the Medicaid program. It may also mean giving providers latitude to take on higher levels of risk, with appropriate safeguards. Minnesota will certainly benefit from efforts by CMS to align payments for those eligible for Medicaid and Medicare, including by having timely access to data needed to calculate payment rates and attribute patients to providers.

The other case studies in our *Aligning Incentives in Medicaid* series look at [Colorado's Accountable Care Collaborative Program](#) and [Vermont's multipayer Blueprint for Health program](#).

INTRODUCTION

Minnesota is implementing accountable care organizations for the state's Medicaid beneficiaries in 2013 and plans to have ACOs for Medicaid and Medicare dual eligibles in 2014. Its safety-net ACO has already begun serving low-income childless adults, and preliminary data show promising improvements are under way. Because Minnesota's integrated delivery systems have long experience in care management, and the state has a good deal of experience in stakeholder collaboration, its experiences may be informative to other states.

DRIVERS OF MINNESOTA'S REFORMS

Minnesota's history of health care reform epitomizes the concept of continuous quality improvement, with health care leaders in both the public and private sector developing and testing incremental changes aimed at improving health care delivery and health outcomes. Many of the reforms rolled out over the past few years resulted from recommendations of the Health Care Transformation Task Force, a legislatively mandated planning team comprising public- and private-sector leaders.¹ The task force's recommendations were sweeping, encompassing health care quality, cost,

accessibility, and the size of the health care system. Some of these recommendations came to fruition as part of Minnesota's 2008 Health Care Reform Law, which created the health home program and the state-wide quality reporting and measurement system. Additional changes, particularly related to the accessibility and affordability of coverage through Medicaid and Medicare, were made possible by the federal Accountable Care Act of 2010. In 2010, additional state health reform legislation enabled the development of accountable care organizations in Medicaid and a safety-net ACO in the Minneapolis–St. Paul area.² A 2011 executive order facilitated ACO implementation and named a new task force with broad stakeholder representation.

Minnesota may be in a better position than many states to implement accountable care because there are integrated delivery systems in much of the state, including many that have broad enough networks to integrate inpatient and outpatient care and have cost and utilization experience that have prepared them to bear risk. Several collaborations between hospitals, health plans, and provider groups began in 2009 and 2010 and led to the implementation of incentive-based payment and shared savings models.

Exhibit 1. Minnesota's Medicaid ACO Initiatives

State Population (2009–10)	5,189,400	
Medicaid Enrollment (#, % of pop.), FY 2009	879,145, 17%	
Medicaid Members in Managed Care Organizations (#, % of Medicaid), July 2010	468,437, 64%	
Payment/Delivery System Reform	ACO Demonstration	Hennepin Health Program
Payers Participating	Medicaid only	Medicaid, Hennepin County
Key Components	Medicaid contracts with provider-based delivery systems as voluntary demonstration sites wishing to be paid under alternative arrangements. Three-year program. Enhances primary care and improves care coordination. Tests payment models that increase provider accountability for cost and quality. Shared savings and risk between providers and state.	Targets nonelderly adults without children in Hennepin County with incomes at or below 75% of the federal poverty level. Uses a medical home approach, integrating health and social services and integrating all care management into a single function. Providers share a comprehensive electronic health record.
#/% Medicaid Population Participating	Implemented January 1, 2013	5,900
Medicaid Participation Goal	100,000 (17% Medicaid pop.) in 2013	Maximum 10,000

Sources for state population, Medicaid enrollment, MCO enrollment: Kaiser State Health Facts, accessed Sept. 2012.

Minnesota’s recent request for proposals for organizations to serve as ACOs drew nine proposals from organizations seeking to serve as Medicaid ACOs, and a tenth (the safety-net ACO) was already in place.³ Three of Minnesota’s ACOs already participate in the Medicare Pioneer ACO demonstration program.

In addition, Minnesota has health care performance data available to inform its policy decisions. State and foundation-funded research about past reform initiatives facilitates understanding of what has worked and what additional reforms may be needed. Minnesota has committed resources to continuing to produce data that will support health care reform, including through the quality reporting and measurement system and the provider peer-grouping initiative described below.

Finally, a key driver of reform in Minnesota, as in every state, is the concern about health care spending, and particularly the growth in Medicaid costs from an aging population, rising health care utilization, and expanding eligibility. Lawmakers wish to rein in Medicaid costs, in particular, to maintain resources for other state priorities. In his 2011 executive order creating the Accountable Care Demonstration Project, the governor named high costs as a problem for families, small businesses, and the state.⁴

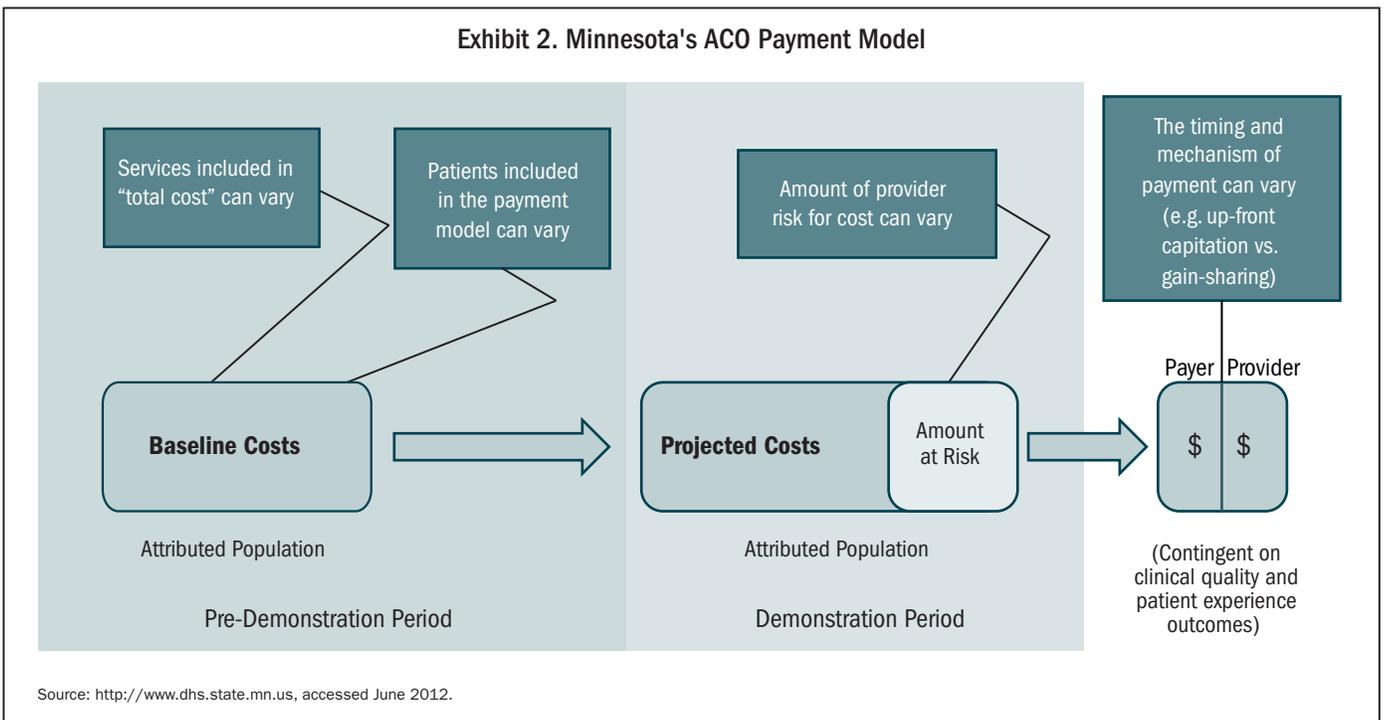
KEY COMPONENTS OF MINNESOTA’S HEALTH REFORM

ACO Demonstration

The 2010 reforms to Minnesota’s health care law called for implementation of Medicaid accountable care organizations to encourage provider innovation in the delivery of high-value care.⁵ The demonstration is intended to enhance primary care as well as care coordination while integrating acute and long-term care with social support services, all of which are expected to reduce costs. ACOs must provide the full scope of primary care, centered around state-certified health care homes or comparable primary care sites. In addition to strengthening primary care, Minnesota aims to promote evidence-based care for diabetes and cardiac care management as well as appropriate hospital care for heart failure, acute myocardial infarction, and pneumonia. Progress in improving health outcomes for these conditions will be monitored using measures defined as part of the Minnesota Statewide Quality Reporting and Measurement System.

The generic ACO payment model is illustrated in Exhibit 2; the state will negotiate payment and risk-sharing levels with each of the ACOs. The state will provide each ACO with information about the baseline

Exhibit 2. Minnesota's ACO Payment Model



Source: <http://www.dhs.state.mn.us>, accessed June 2012.

costs for the attributed population it will serve for a core set of services included in the payment model. The actual costs of providing care for the covered population will be calculated, and the state and the ACO will share in any savings or losses relative to this baseline, based on the degree of risk negotiated. If ACOs improve their patients' health outcomes, they stand to receive additional payment.

Exhibit 3 illustrates potential ACO risk-sharing scenarios. The upper line shows that overspending relative to the benchmark costs will result in the ACO returning the difference between the risk-adjusted projection and the actual expenses. The lower line is the potential savings if the ACO keeps costs lower than the risk-adjusted projection. The level of risk is being negotiated with each of the ACOs. Payments will be made after each performance period during the three-year demonstration; there are no upfront capitated payments.

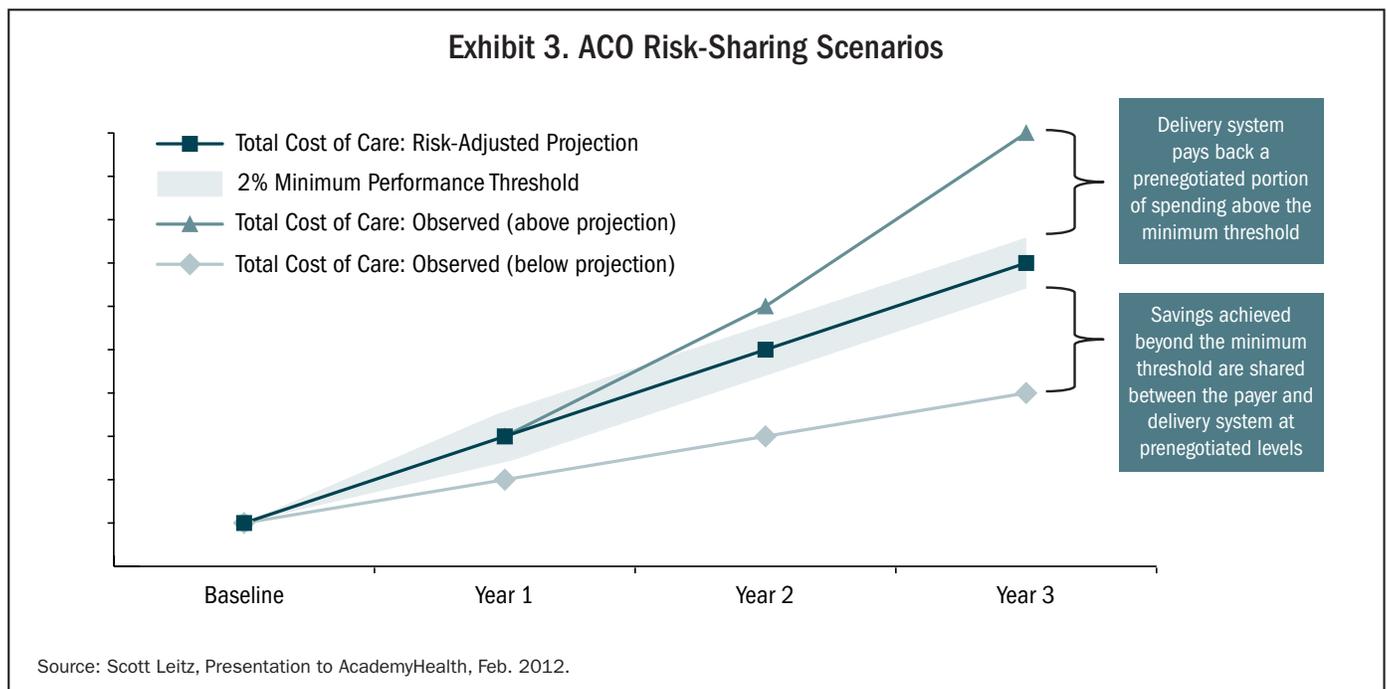
In early 2012, Minnesota solicited bids from organizations wishing to become ACOs in the Medicaid program. Nine groups bid and were selected to work with the state, including eight integrated delivery systems and a consortium of 10 federally qualified health centers proposing to act as a "virtual" health system. Several of the ACOs are also

Medicaid managed care plans. In total, the nine ACOs are prepared to enroll approximately 100,000 Medicaid beneficiaries in their first year. During the summer of 2012, Minnesota Medicaid provided financial and utilization data to each participating organization about the population it can expect to be held accountable for based on the state's patient-attribution algorithm. Contracts between the ACOs and the state involve shared savings in the first year and risk-sharing for the integrated system ACOs in future years.

Participating providers must demonstrate community partnerships are in place to promote input from patients, other providers, and payers. Over time, Medicaid will look for opportunities for different payment arrangements among providers to incentivize transformation of the delivery of care. Though the demonstration program is starting with a relatively small population (17% of the state's beneficiaries in 2013), the state intends to expand ACOs to a larger Medicaid population in the future, as well as to state employees and potentially other payers.

Hennepin Health

In addition to the statewide ACO demonstration program, health care reform legislation passed in 2008 directed the Department of Human Services to develop



a safety-net ACO in the Minneapolis–St. Paul area, in Hennepin County. An ACO was formed among Metropolitan Health Plan (a county-owned Medicaid and Medicare managed care organization), Hennepin County Medical Center, Northpoint Health and Wellness (a federally qualified health center), and an array of social service providers. Hennepin Health was created as a new nonprofit organization and bears risk in its contract with the Medicaid agency for providing the full range of Medicaid benefits. Enrollees get a range of social support services and targeted case management services from the county, which are coordinated with Metropolitan Health Plan via electronic medical records and care coordination meetings. The benefits go well beyond those traditionally delivered through a managed care plan, including services for behavioral health, housing, and food security needs.

Metropolitan Health Plan is working with the Hennepin County Human Services and Health Department to enroll Medicaid-eligible childless adults ages 21 to 64 with incomes at or below 75 percent of the federal poverty level. The program launched in January 2012 with nearly 5,000 enrollees and will enroll up to 10,000 enrollees in 2013. The eligible population had already been getting most of their care through these organizations, particularly the hospital, on a crisis basis, but the various entities had not previously been able to effectively integrate health and social services. Because of patients' complicated health needs, some had several different care managers responsible for different aspects of their care. Under the Hennepin Health ACO, each patient needing care management (about 60 percent of the population) has one care manager to organize all of their physical, behavioral, and dental health care. The state invested in an electronic health record at all provider sites to further coordinate care and share vital information. Many of the patients live in social circumstances that jeopardize their health and health care. Thirty percent are homeless or at risk of losing their housing, and many need food assistance. The ACO program is pooling health and social service resources to pay for services not otherwise available to these patients, such as

targeted case management, training on how to use public transportation (to reach usual sources of health care), and other nonmedical services identified by the care manager—such as housing assistance and work support—which are expected to make it possible to then address health needs. Systems are also being created to facilitate the prompt enrollment of eligible individuals upon release from prison to ensure continuity of care.

Hennepin Health aims to reduce hospital admissions, readmissions, and emergency department use by at least 10 percent and increase primary care use by at least 5 percent in the first year. Utilization data from the program's first quarter (January to March 2012) show that it is promoting appropriate use of care. Over 100 patients who were experiencing dental pain were diverted from the emergency department to a nearby dental clinic; medication management with a pharmacist reduced medication costs by more than 50 percent; medication is being delivered to patients in homeless shelters, thus decreasing the need for transportation services, ensuring timely medication refills, and increasing compliance with medication regimens; and use of the electronic health record has led to reduced duplicative care (e.g., for assessments, referrals, and interventions).⁶ A future evaluation will track further performance measures, including those recommended by the Quality and Data Workgroup (a stakeholder group identifying quality-of-care standards) related to member/caregiver experience and engagement, quality and safety, care coordination, operational efficiency, provider and staff engagement, market impact, and financial indicators.

Program staff report some early challenges related to enrolling and retaining eligible patients, modifying statutes to enable data-sharing across care systems, and finding funding for extra health and social service staff as well as technology enhancements.

Health Care Homes

Minnesota's 2008 health care reform legislation required health care homes, also called medical homes, be made available for all Medicaid, CHIP, state

employee, and privately insured individuals in Minnesota. The health home, which provides enhanced access and coordinates patients' care, is considered a necessary element of system transformation.

Minnesota's Department of Health developed standards for health home certification and began certifying applicants in 2010, including by collecting performance data and conducting site visits to private physician practices, clinics, and community health centers. The certification process involves both data submission and an annual site visit. Practices must meet standards as well as show improvement. Data are being collected for recertification of health homes and evaluation of the program's impact. The measures being tracked include optimal vascular and asthma care, optimal diabetes care, depression remission at six months, and colorectal cancer screening. The state will also track readmission rates using claims data.⁷

The Department of Human Services developed a payment methodology that takes into account patient complexity and psychosocial factors that affect patient management. Per member per month rates range from \$10.14 to \$60.81 with an additional 15 percent supplement for patients who are non-English speakers or have a severe and persistent mental illness diagnosis (the additional payment rises to 30 percent if both are true). The methodology is being assessed on an ongoing basis and adjustments may be made along the way.

As of January 2013, there were 220 certified health homes with over 1,600 certified providers, serving more than 2 million publicly and privately insured patients. About one-quarter of Medicaid patients get their care from a health home. As further incentive for becoming a health home, Minnesota is part of the CMS Multi-Payer Advanced Primary Care Practice demonstration, in which it has said only certified health care homes in the state are eligible to participate.

Additionally, Minnesota has awarded grant funding to three organizations to test a model that integrates the health home with a larger community care team, including staff from organizations that provide a full range of health, social, and economic support services. The Mayo Clinic will test this model of

comprehensive care among elderly patients, the Hennepin County Medical Center will test it among patients using safety-net facilities, and the Ely Clinic will test it among patients with mental health needs.

Statewide Quality Reporting and Measurement System and All-Payer Database

The 2008 health reform law called for the creation of a quality incentive program based on comparison of providers' performance against specific targets as well as improvement over time. The state employee benefit plan and all state public insurance programs are intended to employ the measures, and the state hopes that private payers will follow. In 2011 and 2012, the measures are: optimal diabetes and vascular care in outpatient settings and appropriate inpatient care for acute myocardial infarction, heart failure, and pneumonia. Recognizing that multiple similar efforts exist across the state, and that providers will be more responsive if payers are expecting the same improvements, the state is aligning quality measures used across all programs.⁸ Further, to reduce the reporting burden, private health plans may follow suit by requiring that providers report only this set of measures. The incentives are designed to promote achievement of obtainable goals while also encouraging providers who fall short of the goals but still show strong improvement.

The 2008 law also authorized the development of an all-payer database and risk-adjustment methodology to measure quality and prices for hospital and physician services. The Provider Peer Grouping system is meant to support prudent purchasing by allowing payers, including Medicaid and managed care organizations, as well as consumers to compare provider and health system performance and choose high-quality, low-cost providers. The methodology for calculating rates, risk-adjusting, and achieving incentive payments was released in May 2012.⁹

Competitive Bidding in Medicaid Managed Care

In 2011 Minnesota changed its managed care contracting process to one of competitive bidding, rather than price-setting. Selection criteria for managed care organizations now include both price and quality. Several plans lost business, and 85,000 beneficiaries had to change plans. However, the state was able to save \$175 million in 2012 (compared with \$2.6 billion spent on managed care contracts in 2010).

Dual-Eligible Demonstration

Minnesota has been awarded a CMS contract to develop integrated service and payment models for dual eligibles, or those who are eligible for both Medicare and Medicaid. The model under consideration will integrate medical and behavioral health care, long-term care, and social services. Minnesota and CMS are in discussion about the framework for the demonstration as of early 2013.

Next Steps

Minnesota has plans to continue its drive toward improved care management by submitting a state plan amendment to enable the delivery of targeted services for Medicaid enrollees with serious and persistent mental illness, children with special health care needs, and for maternity and newborn care. With the recent State Innovation Models Initiative grant from CMS, Minnesota will test an accountable care model that is integrated across payers and a broad range of health and social services.

LESSONS

Align Reform Efforts

Over the past several years, Minnesota has crafted a package of health care payment and delivery reforms that are highly consistent in their intent and approach—and the alignment and focus of Minnesota's approach may be a critical factor in achieving transformation. The state has committed to building the capacity of primary care practices to

deliver coordinated, comprehensive, and patient-centered care. Stakeholders within the state have contributed to setting the standard, and the Department of Health has a fully developed program for practices to apply for and receive health home certification. Most payers accept the single medical home standard and pay the same care management fee that is based on patient complexity (number of diagnoses), though Medicare is not yet a participant.

Minnesota also has aligned reform efforts by reaching consensus among payers in the state on a core set of quality measures that are most critical to improved outcomes. It is now working on building consensus on a payment incentive system linked to these measures. The targeted quality measures and incentive methods are consistent with the statewide quality measurement and reporting system, the Provider Peer Grouping system, the private-sector Bridges to Excellence program, and the federal meaningful use standards that promote use of electronic health records.

Elicit Stakeholder Views to Set Priorities and Achieve Buy-In

In shaping its health reforms, Minnesota has sought out the expertise of health care professionals as well as the perspectives of patients. For example, when the state moved Medicaid managed care enrollees to new health plans as a result of the 2011 competitive bidding process, plans losing members participated in the transition to help manage enrollees' concerns. This collaborative approach has likely improved the quality of the state's reform policies and helped achieve buy-in as they are implemented.

Promote Provider Innovation in Health Care Delivery

Minnesota is setting broad goals and patient protections for its ACOs. However, it is leaving the details of health care delivery transformation to providers. State planners hope and expect that given appropriate incentives, providers will innovate to improve the quality of care and achieve efficiencies.

Investing in the Safety Net

As states prepare to cover low-income, childless adults under the 2014 Medicaid expansion, activities like Minnesota's Hennepin Health, a safety-net ACO, can provide valuable experience about how to meet this population's needs. Hennepin Health is working to combine Medicaid and public health programs, case management functions, and funding streams. Minnesota plans to facilitate coordination and information-sharing across providers through the use of a shared electronic health record system and a single case manager.

Streamline Measurement and Reporting

Minnesota has created the infrastructure for providers to report standard, comparable health information for all of their patients, regardless of their source of coverage. This information will help determine the impact of reforms on utilization of services and health outcomes. Reporting is based on a small set of measures the state has prioritized in an effort to minimize provider burden while maximizing attention to problems amenable to change.

HOW CMS CAN SUPPORT PIONEER STATES

The opportunities and guidance CMS has provided to Minnesota have been instrumental in helping the state pursue its health care reform agenda. Going forward, Minnesota will be testing new means of achieving its goals of improving health and health care while controlling costs, and having flexibility to try different means of doing so is likely to be essential to its progress. ACO demonstration projects will explore ways to pay for outcomes rather than services. This may mean allowing care managers to organize and provide services that fall outside Medicaid's traditional purview. It may also mean allowing providers to take on higher levels of risk, with appropriate safeguards.

Payers and providers will need to agree on a methodology that departs from current incentives while not threatening solvency of either party. As Minnesota seeks to align health care payments around core objectives, it may be critical for Medicare payment policies to be consistent with state goals. It will

certainly be necessary for Minnesota to access Medicare utilization and payment data.

CONCLUSION

Minnesota and other pioneer states provide laboratories for health care reform innovation. Policies can be implemented locally to pilot new payment structures and delivery innovations. Minnesota has been a leader in health care reform in the past; as its new initiatives are implemented, the state's experiences will provide additional lessons and potential models for others.

NOTES

- ¹ See <http://www.health.state.mn.us/divs/hpsc/hep/transform/tfreportfinal.pdf>.
- ² Minnesota Laws 2010, Art. 16, Sect. 19, M.S. § 256B.0755.
- ³ J. Silversmith, "Accountable Care Organizations: A Primer," *Minnesota Medicine*, Feb. 2011.
- ⁴ Governor Mark Dayton Executive Order 11 30, Oct. 31, 2011, <http://mn.gov/governor/images/EO-11-30.pdf>.
- ⁵ Minnesota Laws 2010, Art. 16, Sect. 19, M.S. § 256B.0755.
- ⁶ "Hennepin Health—Project Update," Hennepin Health, Minnesota Department of Human Services, May 21, 2012.
- ⁷ Minnesota Department of Health and Minnesota Department of Human Services, "Health Care Homes: Annual Report on Implementation," Report to the Minnesota Legislature 2011, May 2012.
- ⁸ See http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_142133.
- ⁹ "Minnesota Statewide Quality Reporting and Measurement System: Quality Incentive Payment System," Minnesota Department of Health, Updated May 2012.

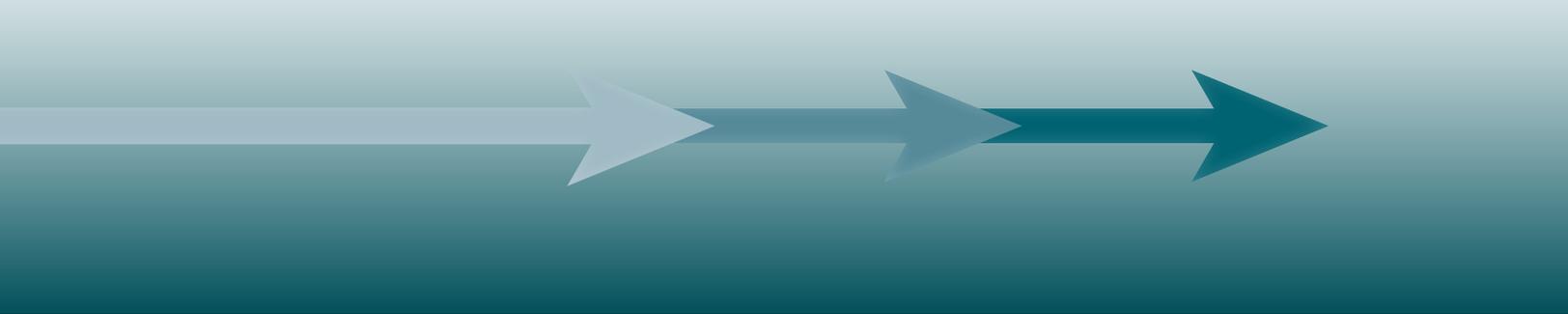
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