



Provider Engagement and Incentives in Care Management

December 9, 2015

2:00 p.m. – 3:00 p.m. ET

Participants

- Ann Mary Philip, Integrated Care Resource Center
- Sue Kvendru, State of Minnesota
- Susan McGeehan, HealthPartners
- Sarah Keenan, BlueStone Physician Services

Agenda

- Welcome, Introductions, and Overview

Spotlight on Minnesota

- State's Role and Approach to Care Management
- Value-Based Purchasing Efforts to Support Care Management
- Care Management Tools for Provider Engagement
- Audience Questions and Discussion

Overview of Care Management Models

Variation in Care Management Models

- Role of Primary Care Physician (PCP) in either leading or participating in Interdisciplinary Care Teams (ICTs)
- Provider composition of ICT, other than PCPs
- Scope/type of required training on ICTs/care management for different providers
- IT tools and usage (e.g., electronic platforms), and related IT support available to providers
- Care coordination (e.g., who's in charge, processes, scope of responsibilities, etc.)

State's Role and Approach to Care Management

Minnesota's Approach to Integrated Care Management

- Joint State/CMS/Health Plan/Provider efforts to achieve Triple Aim goals and meet demographic challenges
- Improve care and costs by working together:
- Combine Medicare/Medicaid primary, acute and LTSS financing
- Align service delivery arrangements
- Create provider level best practice and payment incentives

Snapshot of Care Management Requirements

- Model of Care requirements for D-SNPS with added MLTSS requirements
- Care Coordinators coordinate ICT activities
- Virtual care team options including telephonic and other forms of communication
- Standardized LTSS assessment with HRAs and collaborative care plan
- Implementing universal electronic assessment in 2016

Flexible Care Coordination Delivery Options

- Care Systems (Health Care Homes or Health Care Home Alternatives)
 - Variety of primary/acute care settings/sponsors
 - Use of NPs/PAs combined with RNs and SW as care coordinators
 - Care coordinated across Medicare and Medicaid and MLTSS
 - PMPM for primary care and care coordination including MLTSS
 - Range of risk-sharing and performance-based payment models
- Care Management Organizations/Providers
 - Community organizations and/or providers
 - Establish MLTSS and primary care linkages
 - Some merge behavioral health case management with SNP and MLTSS care coordination
 - May include P4P
- Contracts with Counties (primarily used in rural areas)
 - Includes D-SNP and MLTSS care coordination duties, expands typical county roles to incorporate monitoring of chronic conditions

Tools for Integration: Integrated Provider Payment Models

- Combined Medicare/Medicaid care coordination/case management payments
- Combined Medicaid Health Care Home and Medicaid/Medicare care coordination payments with Medicare and Medicaid Primary Care Payments
- Care Systems: Integrated financing for (mini-ACO like) SNP subcontracts with provider care systems for integrated service delivery and payment reforms across Medicare, Medicaid, primary, acute, and long-term care
- State goal is to increase (scale up) the use of payment and delivery reforms in alignment with other state reform efforts
- Care Systems moving to “Integrated Care System Partnerships” (ICSPs)

Integrated Care System Partnerships

- Expands and builds on current D-SNP/Provider contracting arrangements, leverages Medicare involvement through D-SNP/Provider contracts
- Combined Medicare and Medicaid financing provides incentives for risk and gain sharing across primary, acute and LTC settings
- Incentives to improve health outcomes and choice of care setting
- Seniors: Pooled incentives and payment reforms encourage long-term care provider involvement
- People with Disabilities: Encourages coordination of physical and behavioral health
- Tied to a range of quality and financial performance metrics developed by D-SNPs, clinical experts and State
- All ICSPs subject to state contract requirements for care coordination, quality metrics, financial performance measurement and reporting

Implemented Integrated Care System Partnerships

Range of ICSPs being implemented with different sponsors, target populations and payment models under different plans:

- **Traditional ACOs:** Sub-capitation for all services with risk and gain sharing
- **Health Care Homes (HCH):** Primary care and care coordination PMPM with risk/gain sharing , may include gain sharing against virtual cap for key services
- **Community Behavioral Health Providers:** PMPM for integrated Care Coordination with P4P
- **HCH/Rehabilitation Facility Combo:** PMPM with P4P for primary Care and related support services
- **Long Term Care Organizations:** P4P on gain sharing

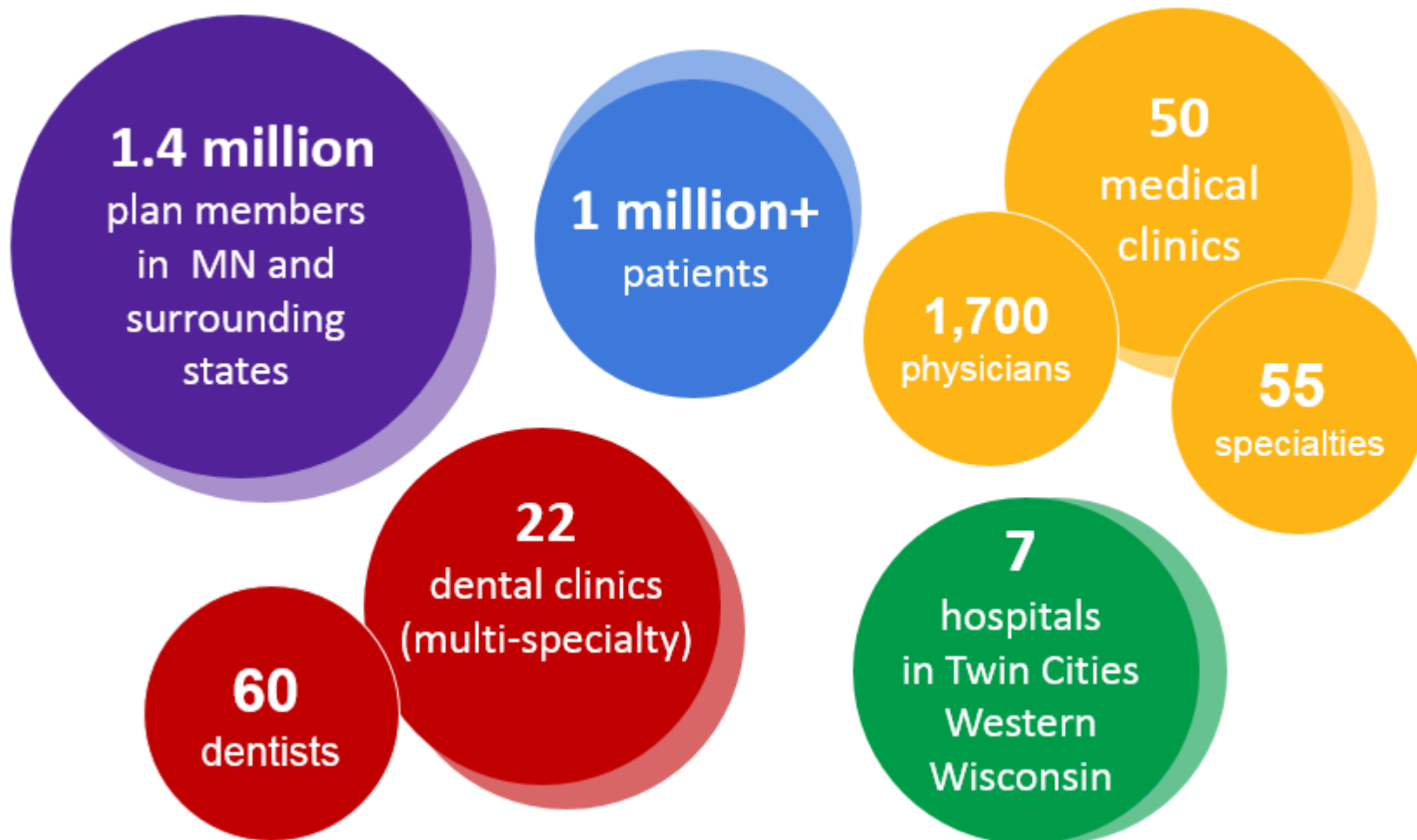
Value-Based Purchasing Efforts to Support Care Management



Provider Engagement and Care Management

HealthPartners Minnesota Senior
Health Options Program

HealthPartners by the Numbers



Mission

To improve health and well-being in partnership with our members, patients and community.

Vision

Health as it could be, affordability as it must be, through relationships built on trust.

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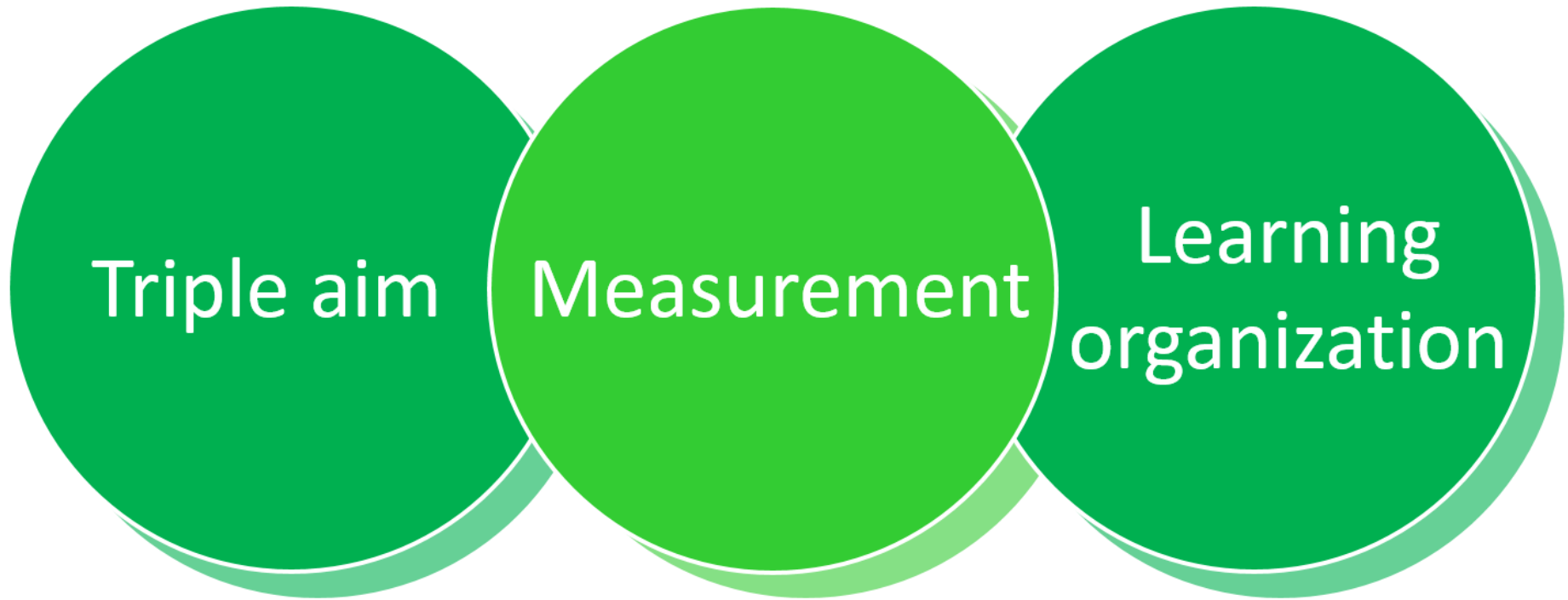
EXCELLENCE

COMPASSION

PARTNERSHIP

INTEGRITY

Our Principles



HealthPartners MSHO

- 12-county service area
- Care coordination model
- Care delivery

HealthPartners MSHO Data use

- Dual eligible data
- Electronic health records for coordination
- Medication therapy management data and program development
- Chronic care team consults

HealthPartners Integrated Care System Partnerships (ICSP)

- MN Department of Human Services contract requirement
- Clinical measures and payment methodology
- HealthPartners ICSPs:
 - Partnership homes
 - Interpreter training
 - Korean service center

HealthPartners ICSP

Partnership homes

- Provide care to **300** MSHO members
- Quality measures
- Coordination structure
- Performance results

HealthPartners ICSP

Interpreters

- Focus on training
- Highly valued in interdisciplinary care team
- Payment model and results

HealthPartners ICSP

Korean service center

- Team: Primary Care, MTM, Care Coordination and HCBS services
- Early learnings
- Quality measures/payment model

HealthPartners Provider Engagement

- What is good for the goose is good for the gander
- As a provider, we understand the challenges providers may have
- Challenges of provider engagement for our MSHO population

HealthPartners Provider Partnerships

- HealthPartners is a learning organization
- Data, data, data
- Importance of measurement

Contact us

Call **952-967-5182**

Visit **healthpartners.com**

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Care Management Tools for Provider Engagement



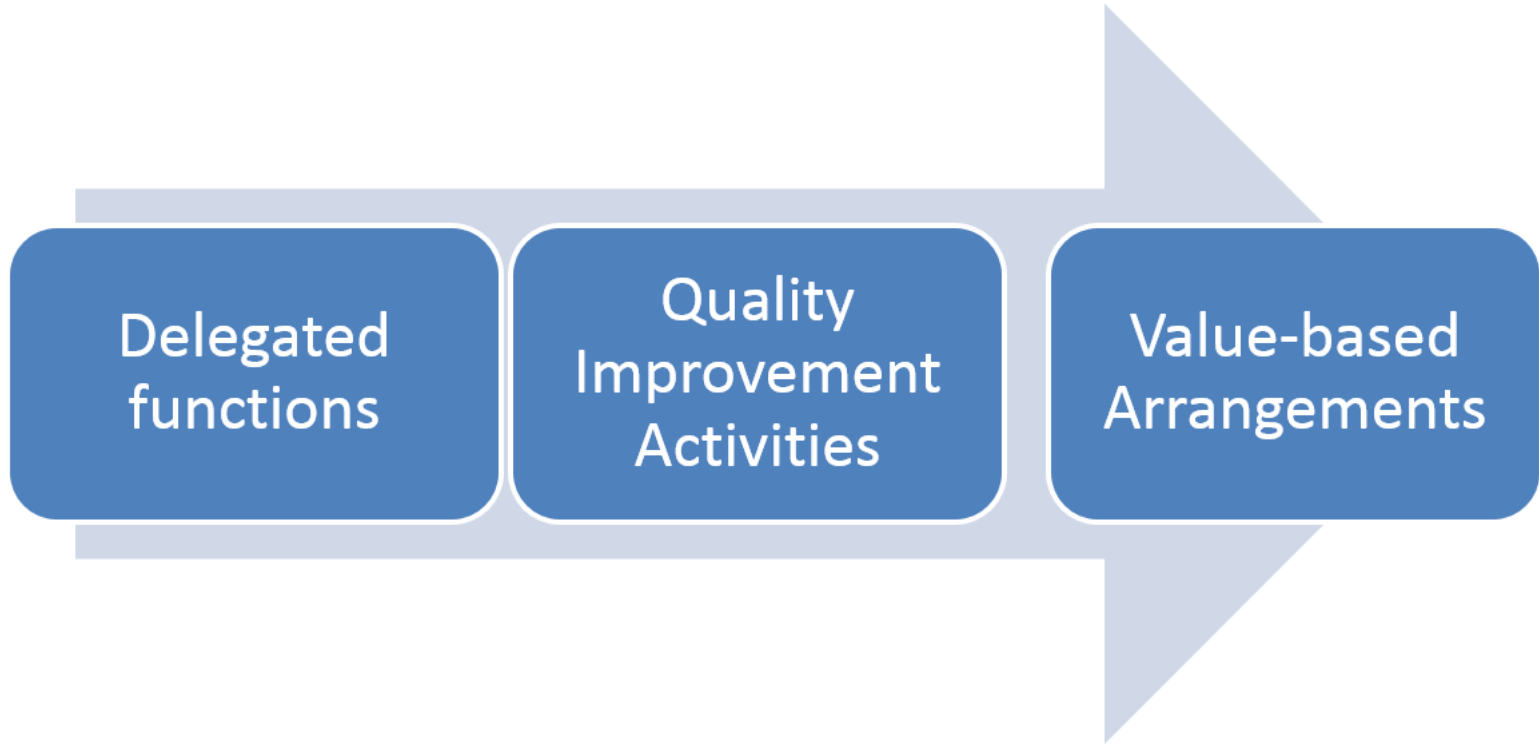
Care Management Tools for Provider Engagement in Minnesota

A Care System Perspective

Sarah Keenan

December 9th, 2015

- Onsite primary care clinic founded in 2006
 - 6000+ residential care patients-MN, WI, FL
- MSHO Care System-2011
 - Ucare-2011
 - Medica-2012
 - Blue Cross Blue Shield-2014



- Multiple payers in Minnesota's MSHO program
 - ***Benefits***
 - Program development and growth opportunity
 - Development of best practices
 - Support and flexibility of State
 - Networking and Learning
 - Improves population health strategies-increased aggregation of patients
 - ***Challenges***
 - Variations on data provided
 - » Determined by each payer

- Range of contract arrangements
- Increased patient related data sharing
- Motivation for new care delivery strategies
 - Patient Outcome Specialists
 - Population-based strategies
- Improved quality outcomes
 - Example – MTM project
- Decreased Costs
 - Utilization management

- Engagement must start at organizational level
 - Development of Infrastructure
 - IT
 - Quality
 - Care coordination
 - Leadership support
 - Physician champions
 - Recognize models of care

- Success factors
 - Cannot be payer dependent
 - Practice-wide initiatives
 - Initiatives and measures that are relevant and repeatable
 - Interdisciplinary teams
 - Clearly defined roles
 - Team meetings
 - Virtual, in person, ad hoc

- Understanding and recognition of primary care trends
 - Multi-payer environment
 - CMS drivers
 - PQRS - MIPS
 - Meaningful Use
 - Population Health
 - Patient Centered Medical Home (PCMH)
 - Chronic Care Management-supports care management activities

Audience Questions and Discussion

About ICRC

- Established by CMS to advance integrated care models for Medicare-Medicaid enrollees
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit <http://www.integratedcareresourcecenter.com> to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: ICRC@chcs.org