

Dental Therapy Toolkit

SUMMARY OF HEALTH REFORM MODELS

March, 2016

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Summary of Health Reform Models

MARCH 2016

After a thorough review, the summary below includes information on the various health reform models in Minnesota, including both state and national efforts. There are opportunities within these health reform models to incorporate dental therapy into the model designs for various benefits including increasing access to oral health care, improving quality of care, decreasing total costs of care, and more.

Introduction

Responding to government- and employer-driven health reform trends, many health care provider organizations are planning and implementing new care delivery models and operating under alternative payment methodologies that are designed to create greater provider accountability and financial incentives to achieve the Triple Aim objectives of improved health outcomes, greater patient engagement and reductions in the total cost of care. Facing stronger incentives to produce better outcomes at a lower cost, providers are developing new ways to deliver and organize care including working in teams, using data to improve quality and control costs, and coordinating care across multiple providers and entities. Providers are also making workforce changes including using more mid-level and paraprofessional workers and utilizing new types of workers who are able to serve in diverse and nontraditional settings, work within teams to increase access to care in a cost effective way and connect with and successfully engage patients in managing their overall health and health care needs. The State of Minnesota is undertaking a multiple agency, public-private initiative, supported by a federal State Innovation Model (SIM) grant to encourage, stimulate and expand these new care delivery and payment models under the framework of the Minnesota Accountable Health Model (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS electionMethod=LatestReleased&dDocName=SIM_Home).

An overarching theme of the Accountable Health Model is integration and coordination of all services needed by patients to address the fragmentation and silos that have existed in the health care system. Initially, the state's top priority was integration of primary care and behavioral health. More recently, efforts have focused on expanding to integration with long-term care, social services, public health, housing, and services to address socio-economic barriers to care that have an impact on a patient or population's health and treatment outcomes.

Up to this point in Minnesota's health care reform initiatives, oral health care has been noticeably absent. Integration of oral health care with other health care and social services has not been emphasized or addressed yet to any significant degree in the Accountable Health Model. However, if the overall integration trend continues on its current course, it is likely that integration of oral health care into health care delivery and payment models will be coming. The relationship between oral health and general health is well-documented and lack of coordination with oral health care creates substantial risks of complications and less than

optimal outcomes, especially for patients with expensive chronic conditions. Even before oral health care is specifically incorporated into the services that are subject to the new accountability framework and payment incentives, better integration and management of oral health will produce better outcomes in those parts of the health care system that *are* included. Oral health integration can be viewed as a major opportunity to further advance the state's health reform goals by expanding the existing reform models to include oral health.

Because the new models encourage use of a wide range of mid-level and paraprofessional providers and new types of practitioners, it is likely when oral health becomes increasingly integrated with other health care services, DTs and ADTs will be important members of the team, along with other mid-level providers and the supervising practitioners. In an Accountable Health setting, DTs and ADTs will be able to reduce costs for routine services and free up dentists' time to practice at the top of their scope of practice -- focusing on more advanced oral health care needs and treatments. As silos in health care are replaced by integrated models, DTs and ADTs will play a key role in health care teams to meet the needs of various populations especially those that face barriers to care and good health related to factors such as culture, race, language, literacy, poverty, geography, and disability.

ADTs are also valuable in new care models because they can provide routine restorative care outside the clinic walls in community settings using mobile equipment, further increasing access especially in rural areas, schools, head start programs, nursing homes and other settings that are more accessible to underserved patients. As the profession continues to grow, and health reform projects continue to increase and expand in Minnesota, DTs and ADTs are likely to become integrated into various health reform models. DTs and ADTs will reach more Minnesotans with oral health needs, which will continue to help close health gaps and reduce health disparities as well as improve overall health outcomes and reduce costs.

The sections below summarize Minnesota's health care reform models. While oral health care is not currently prominent in existing models and projects, it is likely that oral health will be integrated in the future and that DTs and ADTs will play an important role.

Health Reform Models

Health Care Homes

A health care home (HCH), or medical home, is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. The development of health care homes in Minnesota was part of a health reform package that passed through the legislature in 2008 and includes payment to primary care providers for partnering with patients and families to provide coordination of care to improve the individual experience of care, population health and the affordability of health care by containing the per capita cost of providing care.

Health care homes take a patient-centered, team-based approach to health care. The HCH teams make sure that all providers share needed information about their patients' health through patient tracking and care plans and utilize care coordinators to help patients set goals and be active partners in managing their care. HCH providers receive a per-member-per-month payment based on the complexity of the patients' needs. In setting standards and measuring outcomes, HCHs aim to improve enrolled patient's health outcomes through care coordination and ensuring patients receive necessary treatments and follow up care. There are currently over 300 certified HCHs in Minnesota.

For up-to-date information on HCH: <http://www.health.state.mn.us/healthreform/homes/>

Accountable Care Organizations

Accountable Care Organizations (ACOs) are networks of health care providers that band together to provide, arrange or coordinate a full continuum of health care services for an identified group of patients that is attributed to the ACO. The ACO is responsible for achieving the Triple Aim for all attributed patients. In addition to improving health and patient engagement, they are responsible for managing health care costs for these patients, with the goal of reducing the total cost of care. ACOs receive payment incentives (such as sharing in any savings realized for a health insurance plan, employer or government program, called "gain sharing" or "shared savings") if they are able to both reduce total costs of care *and* meet certain quality and patient satisfaction benchmarks. In order to realize savings, it is expected that an ACO will likely shift resources to primary and preventive care, care coordination, and health promotion in order to keep people healthy, prevent or manage chronic conditions and reduce the high-end costs of emergency, crisis intervention, hospital and specialty care.

The growth of ACOs is a trend seen in the private sector, in federal programs such as Medicare, and in state health care programs such as Medical Assistance. According to DHS, participation in ACO models is heavily concentrated among the largest health plans and approximately 50% of clinics, hospitals, and physicians either belong to an ACO or belong to a larger organization that participates in an ACO. In addition, Minnesota's Medical Assistance agency is working to develop broader strategies to increase the alignment of new care delivery and payment models across all health insurers, employers and other "third-party payers," both public and private. In Minnesota, the types of organizations that have formed ACOs include:

- Large integrated hospital-clinic organizations
- Alliances of independent clinics and hospitals
- Safety Net Providers serving low-income and underserved populations
- County health care, social service and public health agencies

For more information on ACO models in Minnesota:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACO

Integrated Health Partnerships

Integrated Health Partnerships (IHP) are ACOs that serve Minnesotans enrolled in the state health care programs: Medical Assistance (Medicaid or MA) and MinnesotaCare. Under the IHP model, the Minnesota Department of Human Services (DHS) contracts directly with providers and networks that have formed ACOs to take responsibility for managing health, patient engagement and costs for an assigned, attributed group of patients, and who can then share in the financial savings if total cost of care is reduced while maintaining or improving quality of care and patient satisfaction. All IHPs have a financial incentive to reduce total cost of care. Some types of IHPs receive gain-sharing or shared savings payments if total costs go down, but aren't penalized if costs go up (called "up-side risk"). Other IHPs accept some financial risk if costs go up and must absorb a financial penalty if total costs exceed the established benchmark for their patients (called "down-side risk").

IHPs are responsible for managing the Total Cost of Care for their attributed patients for a core set of health care services. Patients are attributed based on health care claims data and health care home and primary care provider relationships. Even when attributed to an IHP project, patients maintain their freedom of choice to see the providers they wish to see. Services included in the IHP calculations include the full scope of primary care services and expect IHP participating providers to coordinate care across services needed. Services that are currently not included in the IHP calculations include dental, transportation, long-term care, and residential mental health services.

To calculate total cost of care and the realized savings, the state reviews historical claims data on the costs for serving the same set of patients, then projects forward what the total costs are likely to be in the future if no changes were made in care delivery or cost management. The future projection includes both an inflationary increase in the cost of medical care and risk adjustment if there have been changes in the medical conditions, severity and complexity of the IHP's attributed patients from the historic base year to the year when cost accountability begins. At the end of the year after the new models have been implemented, the actual spending on attributed patients is compared to the projected benchmark to determine if costs were above or below the projection and then gain sharing, shared savings, or down-side risk adjustments are made accordingly. In order to receive any gain sharing or shared savings, the IHP must have met minimum standards for quality and patient experience on standardized measures. According to DHS, the purpose of this model was to "give flexibility to providers to adapt and improve care models to the specific local conditions and the needs of their populations." In 2016, DHS expanded the number of IHP projects in Minnesota from 16 to 19, now covering 340,000 Minnesotans enrolled in Medical Assistance or MinnesotaCare.

Delivery systems that began participating as an IHP in 2013:

- 1 Children's Hospitals and Clinics of Minnesota
- 2 CentraCare Health System
- 3 Essentia Health
- 4 Federally Qualified Health Care Urban Health Network (FUHN)
- 5 North Memorial Health Care

6 Northwest Metro Alliance (a partnership between Allina Health and HealthPartners)

Delivery systems that began participating as an IHP in 2014:

7 Hennepin Healthcare System (Hennepin County Medical Center Hospital and Clinics)

8 Mayo Clinic

9 Southern Prairie Community Care

Delivery systems that began participating as an IHP in 2015:

10 Bluestone Physician Services

11 Lake Region Healthcare

12 Lakewood Health Systems

13 Mankato Clinic

14 Wilderness Health

15 Winona Health

16 Courage Kenny Rehabilitation Institute, part of Allina Health

Delivery systems that began participating as an IHP in 2016:

17 Allina Health

18 Gillette Children's Specialty Healthcare

19 Integrity Health Network

DHS continues to promote the adoption of ACO models in Medical Assistance and MinnesotaCare, and the State's goal is to have 50% of these populations enrolled in IHPs by 2018. DHS is now considering how the IHPs will change in the next generation. This could include expanding the range of services that providers will be held accountable for to include services such as intensive mental health, long-term care, and home and community-based services to serve complex populations. Other considerations for the next generation of the project include expanding the eligible populations, increasing partnerships to non-traditional health care providers and services, and placing an emphasis on integration of acute care and other care settings and services. To guide the next generation, DHS intends to release a Request for Information to gather feedback on the current IHP model and ask participants and those familiar with the model to suggest improvements to work toward a sustainable model while continuing to strive for the triple aim in this population.

For up-to-date information on the Minnesota IHP project:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

Accountable Communities for Health

The Accountable Communities for Health (ACH) program is part of the Accountable Health Model, which aims to transform care delivery, accelerate the adoption of ACO models, and

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address barriers to providers securely exchanging data. The Accountable Communities for Health program goes a step beyond the ACO and IHP models to address broader community issues and social determinants affecting patients' health (such as poverty, homelessness, race or ethnicity, language or cultural barriers) and integrates additional services, providers and agencies into the care coordination and accountability models used in the medical sector such as health care homes, ACOs and IHPs. The ACH model brings together a broader range of community partners, including local public health, social services, behavioral health (which refers to both mental health and chemical dependency), long term care, housing, and other services and agencies that have an impact on a person's health and treatment outcomes. ACHs are expected to address health problems within communities by coordinating support systems across settings and sectors to keep people healthy and stable in the community. An ACH "community" may include the people in a county or other geographic area, a patient population, smaller segments of a community, patients with particular health conditions or socio-economic barriers, or others. In 2014 the state funded 15 Accountable Communities for Health, described in Table 1, which are required to provide, arrange or coordinate the following services and activities:

- Non-clinical services affecting patients' health, including social services, public health, housing, etc.
- Integration of behavioral health, long term care and home and community-based services
- Community-wide prevention efforts to improve overall health and reduce chronic disease
- Measurable community-based goals for improved population health, health care and cost management
- Roles for citizens, employers, providers, health plans, government and communities to participate

For up-to-date information on ACHs:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_ACH

TABLE 1: PARTICIPATING ACCOUNTABLE COMMUNITIES FOR HEALTH SITES

Accountable Community for Health	Area Served	Project Summary
Allina	Anoka-Hennepin School District	Screen high school students in areas of mental health and social determinants of health issues and provide them with comprehensive follow-up, support, and care coordination in health coaching, and linkages to primary care, behavioral health resources, and community and social services resources.
CentraCare Health Foundation	Stearns County	Reduce the incidence of unmanaged diabetes in the Hispanic and East African patient population. Strategies include expansion of the Community Health Worker role and ensuring Hispanic and East African patients are represented in statistical health data.
Generations Health Care Initiatives Hillside	Hillside Neighborhood of Duluth	Meet the health and wellness needs of students and family members from the Myers-Wilkins Elementary School community through a community care coordination model based on building individual and family strengths developed by local public health, healthcare, and social service organizations.
Hennepin County	Hennepin County	Improve enrollment in healthcare programs, improve health outcomes, reduce homelessness, increase employment, and reduce recidivism among clients at the Hennepin County jail and adult correctional facility.
Lutheran Social Services of Minnesota	Anoka, Dakota, Hennepin, Ramsey, Washington Counties	Integrate a Life Plan into care coordination planning for people with disabilities to match the right supports to achieve a person’s priorities at the right time, rather than the current assignment of one standard set of expensive supports for every person who qualifies.

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Accountable Community for Health	Area Served	Project Summary
New Ulm Medical Center	New Ulm and surrounding area	Decrease emergency department utilization and inpatient admissions and improve health outcomes for Minnesota Healthcare Plan participants by increasing home care and rehab referrals, breast and colon cancer screening, and care coordination for those with chronic conditions.
North Country Community Health Services	Clearwater, Hubbard, Beltrami, Lake of the Woods Counties; White Earth Tribe	Work together to increase the region’s capacity to address one of the top concerns in the area: at-risk youth and youth in crisis. The project uses a model for mental health promotion that addresses prevention, promotion of mental health and well-being, crises intervention, and care and advocacy.
Otter Tail County Public Health	Otter Tail County	Addressing the needs of those on MN Healthcare Plans through care coordination and serving clients who access services at the community Salvation Army and A Place to Belong. The project will pilot an improved “no wrong door” approach to care coordination at these sites.
Southern Prairie Community Care	12-county area in southwestern MN	Develop a 12-county wide initiative focused on strategies to prevent type 2 diabetes in those at risk for the disease. Partner with large local employers to increase employee awareness, knowledge, and understanding of type 2 diabetes
UCare/FUHN	Metro area served by FUHN	Redundancies and gaps in the system contribute to low levels of preventive care, frequent visits to emergency departments, and problematic care transitions, even for those with health coverage. The UCare/FUHN (Federally Qualified Health Center Urban Health Network) project will analyze and strengthen the processes of care for Minnesota

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Accountable Community for Health	Area Served	Project Summary
		Healthcare Plan members
Unity Family Health Care	Morrison County	Coordinate chemical dependency treatment and interventions and access to prescription drugs in the senior population.
Vail Place/North Memorial	NW Hennepin County	Develop a collaborative care center for those not accessing their health care home to manage mental and physical illnesses through easy access to providers and labs, chemical and behavioral assessments, case and care management, partial hospital and day treatment programs, care conferences, and care plans
Essentia Health Ely Clinic	Greater Ely area	Continue work of the Community Care Team interagency model of continuity of care begun in 2011 to serve those people living in poverty with behavioral health issues. The project will expand care coordination through additional community health workers and adding new partners.
Hennepin County Medical Center	HCMC Brooklyn Park, Hennepin County, NW Hennepin Family Service Collaborative	Coordinate family-based community interventions focusing on mental health issues. The approach combines social connectedness and healthful lifestyles and improving transitions of care among healthcare, community, and social services, and other supports.
Mayo Clinic	Olmstead County	Link chronically ill adults, their support persons, and nurse care coordinators with community services using the wraparound process to support patient self-management of chronic health conditions.

Source: Accountable Communities for Health, SIM website,

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_achgp#