

Minnesota Accountable Health Model

Community Advisory Task Force

October 2, 2013, 9 am – 12 pm

Wilder Foundation
451 Lexington Pkwy. N.
St. Paul, MN 55104

MEETING MINUTES

Welcome and Introduction

Jennifer Lundblad welcomed members, walked through charge of the Community Advisory Task Force, funding for the MN Accountable Health Model grant, and homework expectations.

The specific charge of the Community Advisory Task Force will evolve as the MN Accountable Health Model is implemented, but will continue to focus at core on using the Model activities to achieve the Triple Aim of improving population health, improving the experience and quality of care for patients, and decreasing health care costs.

The state will receive \$45 million in grant money and while it is a huge opportunity, it won't fix everything. It will also be distributed over three years and in a variety of ways: grants, learning collaborative, etc. The state also needs to achieve \$111 million in savings. Therefore, task force needs to stay focused on the scope of grant and recognize that some issues will need to be prioritized over others.

Update on MN Accountable Health Model Initiative

This will be a standing agenda item.

Diane Rydrych and Marie Zimmerman informed members that feedback had been received on the operations plan. Most states received the same questions; there were no concerns just requests for clarification in a few areas. In particular, what is different under the SIM grant funding vs. building on existing programs. The shutdown has not affected the grant. The state submitted responses to questions to Center for Medicare & Medicaid Innovation (CMMI) last week. CMMI has sent a second set of questions to MN and other states, which are due on 10/25.

Overview of Initial Minnesota Accountable Health Model Straw Proposal

Marie Zimmerman walked through straw proposal document and clarified that the document was created to provide a framework and should not be considered a specific outline of future models and/or funding. The goal is that everyone sees a place for themselves on the straw proposal or in collaboration with an organization that fits the straw proposal.

The chart highlights a continuum of increasing accountability but it is not a linear path. These are capabilities that organizations can fit in broad ways, and organizations may be at different levels for different types of capabilities. Organizations should think through how they fit on the chart. There have been many questions from members on the definition of an ACO, and a strong desire for a more flexible definition; a broad definition is included on the front page of the straw proposal.

Overview of Accountable Care Organizations, Health Care Delivery Systems and the Triple Aim

Shannon McMahon walked through slides.

Slide 11: complex but shows fragmented delivery systems on the left moving towards integrated health models on the right.

Slide 13: Health East and Essentia (members of committee) are part of the Medicare Shared Savings Program. These programs are open and transparent. Pioneer ACO Model has been less public with their contracts. However, Allina offered to share more information on their model.

Task Force member requests:

- Outcomes and challenges from ACO/shared savings programs
- Presentation on what works and what does not work;
- Greater detail and breakdown of slide 11; and
- Feedback from organizations that have received innovation grants.

Slide 14/15: This is a building block for the ACO model. There are 'ACO like' organizations that do this and there are counties that do this. Scott Leitz informed members that the state would like to ensure there is local reward and accountability.

Slides 16/17/18: What providers have the capacity to take both upside and downside risk? What metrics are currently available? Where is there opportunity for information sharing?

Brief discussion on what comprehensive care means and how it is being implemented in MN.

- The Wilder Center is appropriate as it oversaw the homeless center study. Members need to consider the whole spectrum and in particular homeless transition. Clients of

medical care should be discharged to an in appropriate setting will have a greater chance of re-admission to the hospital.

- Need to be sure that the conversation is focused on health. ACO payments are for care, which may not be the same as health.
- There are three categories that this discussion seems to encompass: what is needed, who should be responsible for that need, and who is the most competent to deliver that need.
- Are payers prepared to pay in a different way? Where is the extra money to manage risk? Few organizations are able to take on risk.
- Need to encourage standardized analytics.
- Need to have a broad definition of payer.

Jennifer clarified that overview was provided to ensure all members have background information to discuss the straw proposal.

Discussion of Straw Proposal

Shannon McMahon led discussion; walking members through questions on slide 6. Task Force member comments:

- This feels very medical, how do we ensure that communities feel involved.
- This still a view from the payer or provider. How do things change when they are implemented by the state? What about when the organization or provider does not control the funding?
- It is missing a level 5 or needs more information added to level 4 that incorporates a system change/health of a community.
- How are providers given the tools to pay for new services?
- Need data to be provided in a consistent way across payers.
- Need to ensure that providers are linked to the community. Needs to be a community assessment.
- There is nothing on the quality of performance.
- Where do the homeless fit into the chart? It is hard to see. Dental access and vision loss should also be considered.
 - If the provider is paid for outcomes they will not send the homeless to a shelter.
- Some gaps in system are due to regulations. Is there room in the SIM/MN Model grant for waivers from regulations that may hinder innovation?
 - Scott Leitz informed members that they should not feel constrained by regulation. The state will address concerns that may be raised by CMS.
- Members have to be realistic about change that can be made possible using the grant funding. Employers want to know their role in this will be.
- How will organizations partner with high-risk populations? In particular, tribal

communities that are 'ACO like' but do not have the same resources.

- Straw proposal is missing people/workforce and their satisfaction. People will implement transformation.
- Where is individual responsibility?
- There are limitation of shared data – need to provide intellectual information so that everyone is playing on the same field.
- Need to be clear about ROI expectations.
- Needs to be greater access to community assessment. They highlight the needs of a community so organizations can best address them.

Members mentioned the letter from ARChE

- Jennifer thanked ARChE for letter and encouraged other groups to send similar thoughts or ideas to their fellow task force members.

Dianne Stollenwerk shared information on a project she is working on with the National Quality Forum to identify barriers to integration. Invited interested members to contact her or go to the website for more information.

- http://www.qualityforum.org/projects/population_health_framework/#t=1&s=&p=

Break

Update: Data Analytics/HIT RFI

Diane Stollenwerk walked through slide summarizing task force feedback.

Jennifer Fritz walked through slide on how the state incorporated feedback into the RFI.

Diane asked members if there are organizations outside of those mentioned by the state that should receive the RFI? Suggestions included:

- Tribal leaders
- Rural outreach (Diane Rydrych indicated that MDH has engaged this group)
- Diane encouraged each member to share the RFI with someone
- Many organizations will receive from multiple people, which is good as it will increase likelihood of a response.
- Due date of response cannot be extended as state predicts a great number of responses.
- Request that state tracks feedback to learn which groups/organizations may be missing.

Update: Vision and Goals

Diane Stollenwerk walked through member feedback on the vision and goals document.

Diane Rydrych informed committee of next steps. The state received very rich feedback; over 15 pages of summary comments. Some were just wording changes but many were on much larger concepts. The state will take more time to incorporate feedback, and will bring the revised document to the November meeting .

Next Steps

Jennifer provided information on homework and next meeting.

Key Milestones – first year

Diane Rydrych walked through key milestones.

- The state is contracting with State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to develop an evaluation tool; staff from SHADAC will present in November.
- There will be no meetings in December. By March, it is expected that the committees will have moved to an every other month schedule.
- Question on accountable community for health grants?
 - They are scheduled for October 2014. This year is time to work with existing models and develop selection/performance criteria for ACHs.

Public Comment

- Four people shared support for the ARChE letter. They highlighted that the letter was from community-based organizations that are members of ARChE. They invited the task force to read the letter as it highlights concerns and recommendations.
- Need to ensure that staff and workforce better represent the populations they serve.
- International licensed medical providers need a better path to become licensed providers in MN.
- Representative of the Mental Health Network raised concerns that no one is paying for collaboration or for non-medical providers.
- A supporter of the ARChE letter mentioned that Equality is where everyone has shoes but Equity is when everyone has a pair of shoes that fit.