

Minnesota's Accountable Health Model: Multi-Payer Alignment Task Force

NOVEMBER 22, 2013, 1 P.M. - 4 P.M.

HIWAY FEDERAL CREDIT UNION

840 WESTMINSTER ST.,

ST. PAUL



Agenda

- **Welcome and Overview of Agenda**
- Update: Minnesota Accountable Health Model Initiative
- Straw Proposal and Intersection with Targets, Goals and Objectives
- Evaluation Tool Framework
- Proposed Preliminary Approach to Baseline Assessment of ACO Participation
- Next Steps
- Public Comment

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Straw Proposal and Intersection with Targets, Goals and Objectives

1. Are the program components the right ones?

- Yes, but members want to expand the scope and/or concepts to include:
 - Consumer and patient engagement
 - Population health/disparities reduction
 - Community-based and non-traditional providers

Straw Proposal and Intersection with Targets, Goals and Objectives

2. Are the expectations by levels the right ones?

- Yes, but members want to revisit whether the bar is too high or too low:
 - Level 1 will be too high a bar for some (e.g., soften expectations for incentive arrangements, access to data, access to EHR, create a pre-level 1)
 - Levels 3 and 4 expectations should be heightened (e.g., continuum of care included in shared arrangement, patient engagement, upside and downside risk, data from partners available at point of care to coordinate care)

3. Should the State establish “must haves”?

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EVALUATION OF THE MINNESOTA ACCOUNTABLE HEALTH MODEL

Donna Spencer, Kelli Johnson, Lynn Blewett
SHADAC

Community Advisory Task Force Meeting
Multi-payer Task Force Meeting
November 22, 2013

SHADAC

- State Health Access Data Assistance Center (SHADAC)
- Housed within the University of Minnesota, School of Public Health, Division of Health Policy and Management
- Health policy research and technical assistance center directed by Lynn Blewett, PhD, Professor of Health Policy and Management

CMMI-Required Evaluation Components for SIM Model Test States

1. Federal Evaluation (Cross-State)

- Federal evaluator = RTI International Team Lead
- Required data reporting/participation in Federal evaluation activities
- SHADAC liaison/coordination role with Federal evaluation

2. State Evaluation (Self-Evaluation)

- State has flexibility in setting its own evaluation priorities
- Multi-state agency/committee involvement
 - *SHADAC interface with: DHS, MDH, evaluation and other SIM workgroups, task forces, stakeholder groups, other contractors*
- RTI team available for technical assistance for state evaluation

MN SIM State Evaluation Design Parameters to Date

- Focused on 3 years: 2013 – 2016
- Mostly a formative evaluation: Per earlier discussions with DHS/MDH/Evaluation Workgroup
 - *To inform decision-making and continuous improvement in SIM implementation*
- Focus on initial and interim markers of implementation, processes, and outcomes
- Both quantitative and qualitative methods

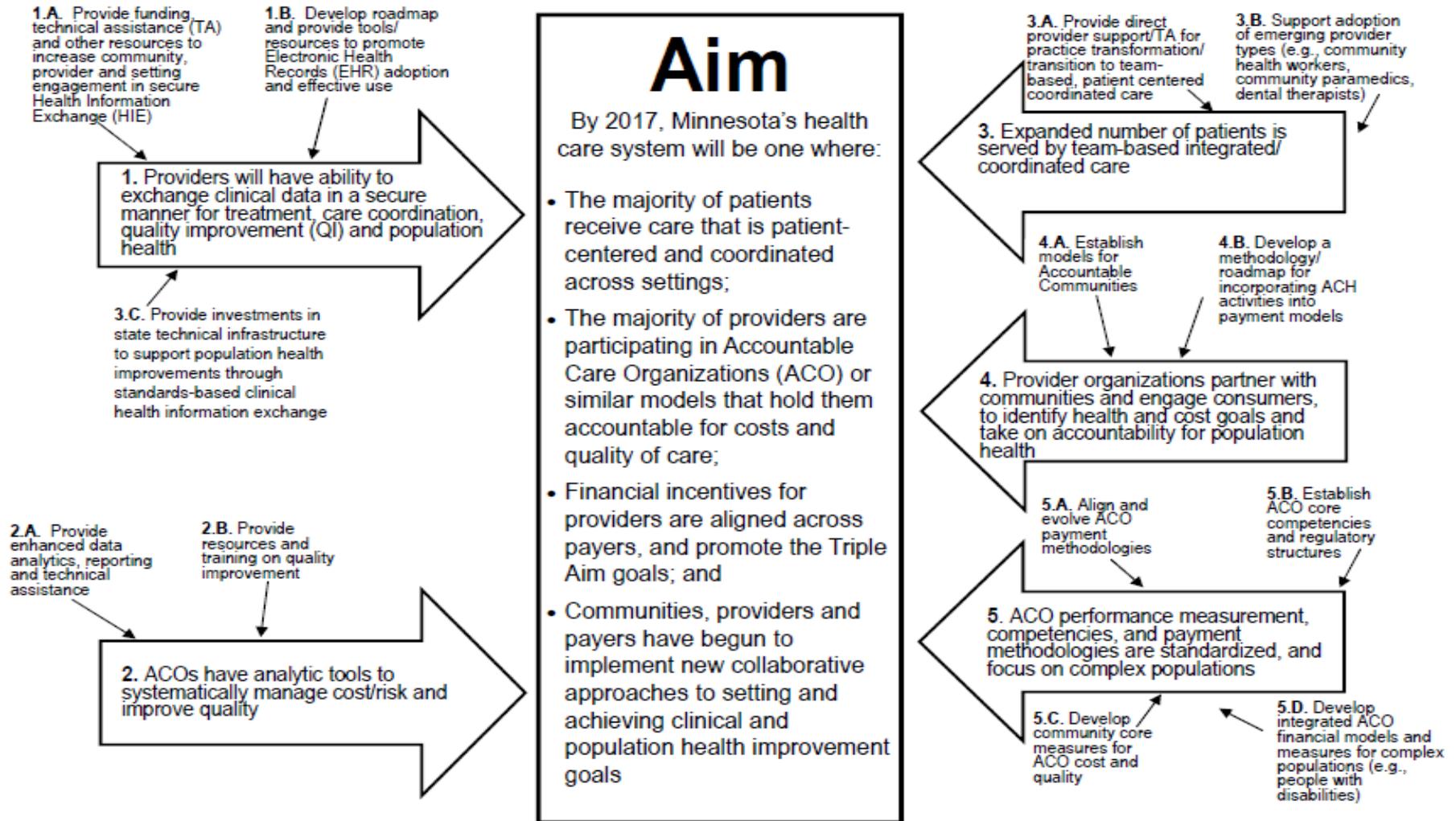
Current Status of MN State Evaluation

- Preliminary evaluation questions and plans included in MN's Operational Plan (August 2013)
 - Developed in collaboration with DHS, MDH and the Evaluation Workgroup (summer 2013)
 - Drafted by SHADAC
- Questions directly aligned with MN's Driver Diagram
 - Per CMMI's guidance to states

Status of MN State Evaluation (2)

- Questions/design organized by each of the 5 primary model drivers:
 1. Providers will have ability to exchange clinical data in a secure manner for treatment, care coordination, quality improvement (QI) and population health
 2. ACOs have analytic tools to systematically manage cost/risk and improve quality
 3. Expanded number of patients is served by team-based integrated/coordinated care
 4. Provider organizations partner with communities and engage consumers to identify health and costs goals and take on accountability for population health
 5. ACO performance measurement, competencies, and payment methodologies are standardized and focus on complex populations

MN's Model Driver Diagram





DEVELOPMENT OF FULL EVALUATION DESIGN

Key Components of Evaluation Design

- Finalize evaluation questions by key drivers
- Identify, define, and operationalize evaluation measures
 - Care coordination, population health measures, total cost of care
- Conduct data scan to identify data sources
- Outline analysis plan
- Develop data collection and reporting timeline for evaluation
- Identify evaluation responsibilities
 - Internal SHADAC/UMN evaluation teams
 - State agency staff and key stakeholders
 - Additional evaluation partners to fill gaps
- Obtain TA from Federal evaluation contractor, as needed/desired

Data Scan to Inform Evaluation Design

- Major step in evaluation design development
- Assess existing data sources, data gaps, and data needs relative to criteria established for Evaluation
- Coordinate with State agency and community data collection activities; e.g.,
 - MDH Minnesota e-Health Initiative
 - Provider HIT Survey
 - Health Economics Program (HEP) data collection and market monitoring
 - DHS quality and cost monitoring
 - Community Measurement, ICSI
- Existing good data to build on

Potential New Data Collection

- Data Scan will inform potential new data collection
- Providers
 - Practice site visits/Case study approach
 - Focus groups/One-on-one interviews
 - Periodic surveys (e.g., quarterly web survey)
- Beneficiaries/Families/Caregivers
 - Patient satisfaction surveys
 - Focus groups
- Payers
 - Focus groups/One-on-one interviews
- State program staff
 - Periodic interviews
- Other?

*Informed by Data Scan.
Refined in Evaluation Design.*

Evaluation Design: Key Considerations

- Delineating and understanding existing/ongoing activities vs. new SIM activities (i.e., isolating the treatment effect)
- Role of health plans and health systems
- Rural and diverse populations
- Comparison groups (e.g., participating vs. non-participating providers)
- Data management and privacy
- Access to claims and other data (APCD)
- Integration with population health initiatives
- Leverage existing data/data collection activities/systems

Timeline for Evaluation Design Phase

Task	Q1 Oct-Dec 2013	Q2 Jan-Mar 2014
Participate in DHS/MDH, workgroup, task force meetings as appropriate to continue to collect evaluation input	X	X
Finalize evaluation questions	X	
Seek federal evaluator TA, as desired	X	X
Identify evaluation measures	X	X
Conduct data scan	X	X
Develop evaluation implementation and reporting timeline		X
Prepare draft and final evaluation design		X

Year 1: Establish Baseline Measures

- Leverage existing data sources
- Provider characteristic data base
 - Characteristics of participating and non-participating providers
 - Coordinate with MDH Minnesota e-Health Initiative to solicit data on EHR adoption and other HIT advancements
 - Use of care coordination, HIE, analytic tools and data for care management
- Technical assistance framework
 - Development of definitions of TA and types of TA
 - Develop tool for monitoring real-time provision of TA
- Case study and qualitative baseline data
 - Recommended web-based provider survey
 - Case study approach for unique Rural/Diverse populations

Year 1 Evaluation Tasks Deliverables

- Conduct data scan
- Complete state evaluation design
- Prepare survey and interview instruments
- Develop baseline data systems
- Conduct data collection as relevant
- Prepare Year 1 report for each of 5 main components of the state evaluation

For More Information

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Evaluation Tool Framework

Question 1: Three or four years in the future looking back on the implementation of MN's Accountable Health Model, what kinds of information will you (your organization/community) need to know to help assess the relative success of this effort?

1. What information could the evaluation produce, specific to various community stakeholders, that would help answer your questions?
2. How do you envision your organization or community using evaluation findings in the future?

Evaluation Tool Framework

Question 2: How can the evaluation team most effectively engage Task Force members to leverage your knowledge and perspective to improve the evaluation design and implementation?

1. What existing evaluation/assessment/monitoring/quality improvement efforts should we be aware of to inform our evaluation going forward?
2. What data/information does your organization or community collect that we should be aware of and potentially use as part of the evaluation effort?

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BASELINE ASSESSMENT OF ACCOUNTABLE CARE IN MN

Discussion with the SIM Multi-Payer Alignment
Workgroup - Nov. 22, 2013

Stefan Gildemeister
Director, Health Economics Program

Minnesota's State Innovation Grant Goals

- Every patient in Minnesota receives:
 - Coordinated, patient-centered primary care
- Delivery system is characterized by:
 - Payment model that is based on quality, patient experience, and cost performance
 - Payment arrangements that reward providers for improving health
 - Partnerships across sectors to integrate behavioral health, mental health, public health, long-term care, social services, and other providers to share accountability for population health

Key Components of Accountable Care – An Example

Data analytics	Timely data on cost & utilization to inform decision-making, promote quality, and monitor use of resources
Payment incentives	Shared-savings structure to promote lower costs and coordination
Accountability measures	Used to ensure value, not only cost containment
Identified population and system of care	An identified target population (by region, community, or group) whose care can be tracked and managed and a system of care to serve that population
Continuum of care	Minimal ACO components include strong primary care practices, at least one hospital, and specialists

Source: Purington K et al. *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*. New York: Commonwealth Fund.

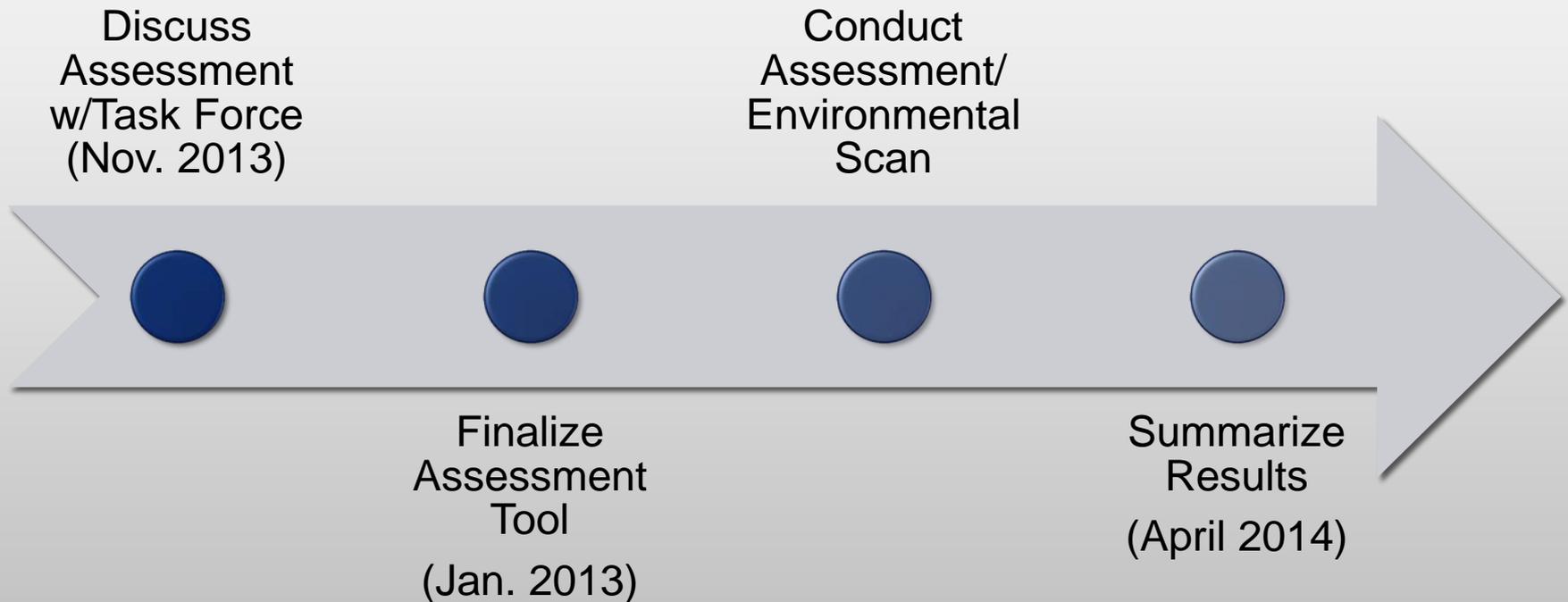
What Do We Know About Accountable Care in Minnesota?

- Medicare Pioneer ACO program (Allina Hospitals and Clinics, Fairview Health Services, and Park Nicollet Health Services.)
- Medicare Shared Savings ACO program (Community Health Network and Essentia Health).
- Other Minnesota providers/health care systems share aspects of ACO model (e.g., HCMC, Mayo Clinic).
- HCDS Demonstration Medicaid ACO (6 current HCDSs, expanding in 2014 and subsequent years)
- MN Organizations among the first to receive accreditation from NCQA (HealthPartners and Essentia Health)

What Do We Need to Know for a Complete Understanding of Accountable Care in MN

- Scope of accountable care
 - Number of organizations with these arrangements
 - Number of individuals covered under these arrangements, by market space
 - Type of sponsorship
- Characteristics
 - Structure of provider network – virtual vs. within-system & governance structure and community involvement
 - Levels of risk sharing and performance criteria employed
 - Durations of contracts
 - Data analytics capabilities & extent of data exchange between parties
 - Degree of coordination across continuum of care

Anticipated Timeline for Assessment



Questions for Discussion

- What other concepts do we need to better understand?
- Which type of accountable care are we particularly interested in – P4P vs. shared savings vs. ??
- What method of data collection would be best suited to the effort?
- What available research should we consider in the process?
- Should data collection be paired with qualitative assessment?
- Which organizations should we approach?

Contact and Add'l Information Available Online

- Stefan Gildemeister (MDH): 651-201-3554,
stefan.gildemeister@state.mn.us
- Sara Bonneville (DHS): 651-431-2635,
sara.bonneville@state.mn.us

- Health Economics Program Home Page
 - www.health.state.mn.us/health/economics
- Health Care Market Statistics (Presentation Slide Decks)
 - www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html
- Interactive Health Insurance Statistics
 - <https://pqc.health.state.mn.us/mnha/Welcome.action>

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Next Steps

- Next Meeting: January 16, 2014
- Location: 179 Robie Street East, Rm 272, West Side Room, St. Paul

Contact Information

- Multi-Payer Alignment Task Force
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