

Minnesota Accountable Health Model

Multi-Payer Alignment Task Force

Wednesday, November 19, 2014, 1 p.m. – 4 p.m.

Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar Street, St. Paul

MEETING MINUTES

Attendees

Charles Abrahamson, Beth Monsrud, Jennifer DeCubellis, Diane Rydrych, Nathan Moracco, Garrett Black, Jennifer Blanchard, Christine Reiten, Jim Przybilla, Brett Skyles, Manny Munson-Regala

Welcome and Overview of Agenda

Garrett Black, Chair, welcomed everyone and provided an overview of the meeting agenda.

Update and Discussion: Data Analytics Subgroup

Dr. Rahul Koranne, HealthEast and Chair of the Data Analytics Subgroup, provided an update on the Subgroup and its first meeting on November 17:

- Dr. Koranne thanked the individuals and organizations who volunteered individuals for the Subgroup.
- 14 individuals applied for membership in the Subgroup, and they have their eyes and ears open for feedback from their organizations and the community at large. The first of three meetings is complete, which means there are only six hours of meetings left before Phase One of this work is completed, we need to focus on “what we can create today”.
- The Subgroup is comprised of a good continuum of leaders across healthcare system: some come from organizations that are experimenting with ACOs, both with DHS and commercial payers, while some come from innovative social services community-based agencies that are starting into the ACO world, or thinking about total cost of care (Wilder and others).
- Dr. Koranne noted that part of the work is to think about how to wear hats in the room – keeping your own organization’s hat on, but also thinking collectively for the State. He thanked Krista O’Connor, Heather Petermann, Chris Heiss and Diane Stollenwerk for their help keeping those frames in mind.
- Key topics at the first meeting:
 - Good discussion about “are we starting from square 1, or are there other organizations that can come in and give us a baseline?” Presentations from outside organizations (ICSI, MNCM, Stratis, SHADAC) provided some of this flavor. But this was a structured discussion – the Subgroup realizes that we need all the help we can get, but wants to gather feedback and move on, because we need to take the plane off the ground then land it in a short amount of time.
 - Phase One vs. Phase Two discussion – guardrails for Phase One around what can be done today in terms of ACOs, Phase Two will focus on ACHs and the further integration of medical and social services data.

- There was a good dialogue between the medical, integrated delivery ACO types and the social service agencies about where the focus should lie in Phase One. How do we go from today to tomorrow so that we don't forget about social elements in Phase One?
- Scalability – How do we make sure our work applies to small/ large, urban/ rural, medical/ social organizations?
- When the Subgroup comes up with a product (data elements, source, guidebook) – who should/ would these guiding principles apply to? Medicaid ACOs, other ACOs, all ACHs?

Diane Stollenwerk, CHCS noted that individuals came into the meeting with a variety of perspectives – some with big-picture questions, others with a specific list of data elements to be provided in mind. Monday's discussion helped get a sense of where people were coming from, allowed people to put out the questions or detailed analytics, showed that there ought to be a connection/ correlation between those things. Some other key ideas included identifying the value chain around data analytics – if the end-goal is to create a risk profile of the population stratified by demographics, what will that risk profile be used for? To some organizations, it's obvious, to others, not so obvious. Tina Frontera from MNMCM mentioned how there are gaps in data/ data transfer.

Task Force members provided a range of comments:

- Beth Monsrud noted that the “to what end” purpose will be very important. How you take data and use it for business purposes is very key.
- Jennifer DeCubellis noted that there is a lot of interest from providers in being at the table to solve both the cost and outcome pieces of the question. But without the data you can't do that. Standardization of information from payers will be very important. Payers often tell the providers to give us the business case for what you're doing to drive outcomes – Lutheran Social Services told Hennepin that it can't do that because they don't have the cost data. Jennifer followed up with George Klauser to say “tell me who you have that is in MHP, so that we can give you the data.”
- Nathan Moracco asked if there was any correlation between what the Data Analytics Subgroup is working on and the work of the MDH administrative uniformity commission (AUC) – there may be overlap in representation and perspectives (though the Subgroup is not getting down to the coding level). The Administrative Uniformity Commission has been around for 10 years – perhaps they could advise/ facilitate. Diane Rydrych replied that preliminary conversations are happening, and that Nancy Garrett has reached out to determine where they have a role. AUC work is very technical – data standards – and the Commission may not be comfortable playing a role of what the data should be, but could be helpful regarding the operationalization of that data. Dr. Koranne stated that he will make sure that the Subgroup hears from the Commission and vets with them the direction that we're going.
- Dr. Koranne noted that the Subgroup also discussed the tension between patient-level claims data and community/ population level data, and the need to do both simultaneously, then take a deep-dive.
- Diane Stollenwerk noted the issue that no single entity that will make everything consistent. The Subgroup will be creating principles, and hopefully there will be enough of a value proposition/ business case for organizations to start to use the principles to move toward uniformity. But there is no expectation that there is any requirement for anyone to do this - guidelines are very different from having a set of requirements. Which raises the question – is the Subgroup going to do all this work and then have it sit on a shelf? What should be in place to enable/ encourage alignment? There has to be value in doing it, so that the “what's in it for me” from an organizational perspective makes sense.

Minnesota Accountable Health Model: Looking back/looking forward on task force accomplishments

Assistant Commissioner Nathan Moracco, DHS, provided his thoughts on the Accountable Health Model and the work the Task Forces have done over the past year:

- There was a great discussion this morning in the Community Advisory Task Force, and the two Task Forces individually and as a collective are very engaged. That is a testament to how the groups have evolved over the year - when we first started a year ago, members were looking at each other trying to figure out what we were doing around the table.
- Looking for folks to continue to stay engaged – the subgroups are moving along, and will prove to be very valuable for this group; they are a great outgrowth of this activity.
- As we consider what we're looking for in 2015, we're looking at the lessons learned from the various grant awardees, Phase One and Two of the Data Analytics Subgroup, and how to manage and integrate with the broader set of stakeholders.
- At some point it is difficult to not translate the work in SIM into some sort of legislative work. We don't want to get too mired in that, but will be moving in that direction at some point. We also need to start talking sustainability so that the money/ time invested live longer than the 3 years of the SIM grant. The State will be asking more and more of those questions over the next year.

Garrett Black noted that he was excited for 2015. As a group, we've broadened our perspective in 2014, but will look forward to the insights from grantees and the Data Analytics Subgroup in 2015. For DAS, while we have good data in some areas, there are data deserts, particularly for managing health care disparities.

Update: Minnesota Accountable Health Model

Jennifer Blanchard, DHS, provided updates on the Minnesota Accountable Health Model, including:

- Jennifer commented that there is a group of staff putting in a lot of time and effort to get RFPs out and support provider groups and organizations in their applications.
- There have been two successful rounds of the [Emerging Professions](#) grants, with lots of interest expressed from a large number of many different providers.
- The first round of the [E-Health](#) grants is moving into implementation; Round 2 will be released in the spring.
- The RFP for [Accountable Communities for Health](#) (ACH) closed October 20. The review process is complete of the 25 submissions and the top 13 applicants gave oral presentations. Decisions will be finalized in the next week or so, with announcements anticipated by the first week of December. Jennifer commented that it is exciting to see the types of groups that have come together – some that we expected, some not, with a variety of models and target populations.
- A number of other RFPs are open, and most close December 5th. All details on those RFPs can be found on the MN SIM website.
 - [Emerging Professions Toolkit](#), providing resources to potential employers of emerging profession practitioners (community health worker, community paramedic and dental therapists/advanced dental therapists) to support integration of the emerging professions into the workforce.
 - [Privacy, Security and Consent Management for Electronic Health Information Exchange](#): to support health care professionals, hospitals and health-related settings in the exchange of information within health settings, including improved information flows to patients and increased patient satisfaction.
 - Part A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice
 - Part B: Technical Assistance and Education to provider groups to do consent management

- [Practice Transformation](#): To support care coordination and integration of behavioral health and primary care. This is the first of three rounds.
- [E-Health Roadmaps](#): To describe a path forward and a framework for a setting to enable providers to effectively use e-health to participate in the Minnesota Accountable Health Model. The state is securing the contractor for this work.
- ACO Baseline Assessment: The State has secured a vendor and is in contract negotiations with them.
- [Practice Facilitation](#): asking providers for input about desired technical assistance and support needed for internal quality improvement and cross-provider service integration. There will be a December 2 forum at the Wellstone Center to bring in community providers to discuss what practice facilitation/ TA would look like for them.
- Grant and contract Management:
 - The third quarter 2014 report and the Year Two operations plan were successfully submitted to CMMI through a new reporting method. Jennifer thanked the staff for their hard work.
 - Work to evaluate the MN SIM project is moving forward with SHADAC.
 - Staff are working diligently to make the MN SIM website as user-friendly as possible.

Diane Rydrych noted that there is a lot of work going on, and that things have really accelerated in the past few months. The State is looking for opportunities to bring grantees to Task Force meetings to learn from them – ACHs, e-health community grantees – to take what they're learning and help shape what we're doing over the next couple years.

E-Health Advisory Committee Activities

Alan Abramson, HealthPartners, provided an overview of the E-Health Advisory Committee:

- The E-health initiative was established by statute in 2004 to equip providers with inter-operable records by 2015. The committee is a broad-based group of stakeholders that has advised the Commissioner of Health for the past 10 years.
- Accomplishments over the past 10 years include:
 - Working with the Minnesota Legislature to recognize the existence of Electronic Health Records (EHR).
 - Creating a three-phase plan for establishing inter-operable records by 2015 (equipping with records, effective use, then exchange of data across the state) that the Federal government borrowed heavily from.
- Conducted an audit survey in June 2014 and found that Minnesota hospitals have achieved 99% installation, public health 97%, most providers 96-97%. Long Term Care providers asked to be included, and though not reimbursed for the work, stand at 70% installation of EHR.
- The Committee is beginning to talk about population health, accountable health and how EHRs coordinate with that work.
- The Committee is scheduled to sunset in 2015, but Alan thinks that there are reasons to renew the charter, particularly as organizations determine how to use EHRs.

Jennifer Fritz, MDH, provided an overview of Committee workgroups and their activities, and invited Task Force members to participate:

- The workgroups dive deeper into E-Health topics than the broader committee. Each year there are between two and four active workgroups (right now there are four).
- Health Information Exchange (HIX) workgroup: will hold its first meeting on December 4, to discuss how HIX can be used to achieve accountable care. A panel of ACOs will be presenting. The first couple of meetings will focus on gathering emerging needs. The remainder of year will be

focused on what transactions need to be in place to meet the 2015 mandate, and that may be relevant to accountable care. Final activity of the year will be to update resources.

- Standards and Inter-Operability workgroup: has some interesting ties to the work of the Data Analytics Subgroup. There was a meeting a couple of weeks ago on capturing social determinants of health on EHRs, drawing off of a recently-published document from the Institute of Medicine. Minnesota was the first state to recommend that all providers adopt the same terminology as provided by the Omaha System for Public Health. The next conversations will be around inter-operability in state government, as the Commissioner of Health has responsibility for recommending standards.
- Privacy and Security workgroup: all of the SIM privacy and security work will go through this workgroup. The workgroup will provide advice on approaches to patient and provider education, consumer-based education to better explain how data is used/ stored/ disclosed, and legal analysis around privacy and consent policies. It will develop resources and guidance on resources, particularly for those not part of the bigger health systems. Work will continue through the duration of SIM.
- E-prescribing workgroup: Most of this workgroup's work is already done, but it may still meet later this year to take deep-dives on specific instances of e-prescribing.
- The Committee also has a couple of ad-hoc workgroups in place to address Consumer Engagement and Workforce issues.

Task Force members commented on the presentations from Alan Abramson and Jennifer Fritz:

- Garrett Black noted that the charge of the Commission should be updated to indicate what legal entity is needed to ensure that information is able to be exchanged between and ACO/ACH/social entities. Keep consumers in mind as you think about portability of health records - what happens when you see a specialist outside of the ACO? How do we make it easier for consumers to make their health records portable? Maybe not the entire record, but pieces of it (medications, etc.). A uniform consent form is needed for consumer – that could be an area to streamline for consumer satisfaction.
- Nathan Moracco asked if the group has thought about another 10 year milestone. Alan Abramson stated that is one of the reasons why they are presenting to the Task Forces. What are the key elements moving forward? How do consumers get involved? What about population health models?
- Charles Abrahamson noted that it is helpful to look at existing models to determine what might be needed 10 years from now:
 - Advancing interoperability aspect across continuum that supports consumers and providers
 - Standardization, portability, across the entire system with medical and welfare systems. We need to leverage each system to get the best results.
 - Providers that deal with social determinants need to be incorporated into the system – how does all of this work with Total Cost of Care?
- Jim Przybilla noted the regulatory compliance and surveillance issues that health plans must meet. Plans spend a ton of money on chart goals, NCQA with paper charts.
- Garrett Black said that a different statute is needed to support the use of various registries, including disease registries, as a community health resource.
- What can the TF do to support the work of the e-health advisory committee continuing their work?
- Beth Monsrud noted there is potential overlap between the Data Analytics Subgroup and the E-Health Advisory Committee.

Minnesota Accountable Health Model Evaluation

Lynn Blewett, SHADAC, provided an overview of the Minnesota Accountable Health Model Evaluation:

- This evaluation is a “formative evaluation,” meaning that it is a joint, collaborative project, where SHADAC will be working with State staff and the evaluation committee to get the best information possible. It is not the type of evaluation where the evaluator shows up three years later to say what was done wrong.
- The evaluation contract was finalized this summer. Part of the work since then has focused on establishing working relationships between team leads. SHADAC is also working with Hennepin Health evaluators, who have similar goals.
- SHADAC submitted the draft evaluation plan on 10/31/2014 and received the first feedback on the plan on Monday, November 17. The final plan is due in early 2015. The draft plan is very complex, and is 70 pages long. Once feedback and edits are received and compiled, the draft plan will be made available to the committees. The plan outlines the five evaluation goals, with evaluation questions for each goal, and cross-driver evaluation activities. Part of the work is to identify and leverage existing data sources, then seeing where there are gaps.

Task Force members asked a range of questions:

- Shannon McMahon, CHCS, noted the conversation in the Community Advisory Task Force that SHADAC is coordinating with the national evaluators (RTI) to make sure that questions are answered at the right time. Lynn Blewett commented that SHADAC wants to make sure individuals are not approached with the same questions the day after the national evaluators ask the same question.
- Garrett Black asked how the Task Force could support the evaluation efforts; Lynn replied that it will be important for support once the evaluation is under way and nitty-gritty questions start coming up.
- Jim Przybilla cautioned to not be too wed to the national evaluation. He hopes to get results that inform policy changes, but is skeptical on the kinds of data that can be collected in two to three years.
- Diane Rydrych noted the tension between the federal and state evaluations: The federal evaluators are looking for commonalities across 6 SIM states, but looking at very broad metrics, which may not be right for MN. MN will have a much more nuanced vision of how things have changed.
- Jim Przybilla noted that in the first year of these projects you often find a lot of low-hanging fruit. But in terms of bending the cost curve, that happens over multiple years. Diane Rydrych agreed, saying that state-wide population health metrics only change over a long-range timeframe. Jim noted that moving the culture towards Total Cost of Care is a huge shift that can be measured.

Review Next Steps/Future Meetings

Garrett Black wrapped up the presentations, noting that this was the last meeting of 2014, and in 2015 the plan is to move to a quarterly schedule, including one or two joint meetings with the Community Advisory Task Force. Short conference calls or webinars may also be scheduled to prepare members for in-person meetings, to make the most of in-person time, and we are already anticipating an early March webinar to share the output of Data Analytics Subgroup Phase One, to prepare for the March 18 meeting and get alignment around Phase Two. The next in-person meeting is scheduled for March 18, 2015 at the Wilder Foundation in St. Paul.

Task Force Members asked closing questions:

- Nathan Moracco asked what was envisioned for the last Task Force meeting of 2015 – would the Task Force be winding down, handing off, or continuing forward in 2016? Diane Rydrych replied

that there wasn't a great sense right now, but that she thinks there is a lifecycle to this type of Task Force. There was a lot of initial input on shaping the grants and RFPs, now we're shifting into learning from them and feeding into next cycles of work. The SIM grant goes until the end of 2016, but long before then we need to talk about what we learned from SIM work, but also barriers and opportunities to sustainability.

- Garrett Black noted that the conversation started yesterday around how to collect information from the various groups involved in SIM. It is on the leadership's radar. Leadership should think about a summary report that codifies all the work of the Task Forces.
- Diane Rydrych stated that the other part of the conversation is that the State isn't the only one doing this work. What are the implications of what we're learning for the private payers?
- Jim Przybilla asked what we think we should be at the end of this project - do we feel any more aligned at the end of these 15 months? The work over the next year should be about getting to the tougher alignment question. He keeps hearing from providers about what other payers are doing and could they do those activities - the State could come up with standards that could benefit all members.
- Garrett Black said that the best opportunity for alignment will be vis-à-vis the data analytics work. A lot of the Task Force's work last year was contributing to RFP processes. Jim Przybilla replied that maybe the Task Force could work on knocking out some safe areas of alignment first, then take on the tougher, more substantive items.

Public Comment

Virginia Barzun of the Minnesota Academy of Family Physicians, said it would be lovely if "professional satisfaction" was added to the measures for the evaluation. Are we limiting burnout in primary care? Monitoring access to ensure that what is happening is not limiting access to care. Garrett Black replied that it is an important perspective, particularly as we have multiple policy initiatives driving access, and need to worry that it doesn't overstretch existing resources.