Minnesota Accountable Health Model

Multi-Payer Alignment Task Force

October 3, 2013, 1:00 – 4:00 p.m.

Hiway Federal Credit Union
840 Westminster St.
St. Paul, MN 55130

MEETING MINUTES

Welcome and Introduction
Garrett Black welcomed members, walked through charge of the Multi-Payer Task Force, funding for the MN Accountable Health Model grant, and homework expectations.

The specific charge of the Multi-payer 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 collaboratives, technical contracts, 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. More detail will be discussed in November.

Marilyn Cook, Garrett’s support person, will contact all members to set up a 30-minute time to discuss the task force. In particular, members’ concerns and ideas.

Update on MN Accountable Health Model Initiative
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.

Update: Data Analytics/HIT RFI
Diane Stollenwerk walked through slide summarizing task force feedback.

Heather Petermann 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?

- United Way grantees
- Tribal Health Directors
- Each member should share 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.

**Overview of Initial Minnesota Accountable Health Model Straw Proposal**

Dianne Hasselman walked through slide on Impetus for Accountable Care Organization and Triple Aim.

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 every organization sees a place for itself 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. Organizations should think through how they fit on the chart. There have been many questions from members on the definition of an ACO; a broad definition is included on the front page of the straw proposal.

Dianne Hasselman led discussion; walking members through questions on slide 13.

- How do you know a system/community is ready?
- It is still very systematic and medical focused. May inadvertently create something the state does not want.
- Need to add a community set of levels, payer row, consumer row, and state row.
- Add examples in the data analytics section
  - What is the minimum set of data that will be required of each client?
- There needs to be minimum requirements for each level – something that organizations must meet before they can move to the next level.
- Organizations should be able to be at different places on the metric but still move from left to right.
- Internal/cultural infrastructure
  - Some of these are examples and some of them are must-haves
  - Some groups are very familiar with measures and some are new
- Is there an assumption that you get a return on investment at some point on the continuum?
  - Some investments will take many years before there is a return
This is focused on input. There may be structural necessities that may not get savings but will be required in order to move along the continuum.

A level 1 may be a cost but a level 2-4 may be a savings. There is a concern that this will inhibit some organizations from investing.

- Needs to be a hypothesis to each, add an ‘if’ statement to the straw proposal
- There needs to be an outcome column.
  - There is an outcome based on the triple aim.
  - The target should be the triple aim.
  - At every level there should be a strong push for coordination on output/outcomes

- Providers need alignment among payers.
- There is a difference in prioritization between public health and medical care. Medical care gets more immediate results.
- Must be careful, as it is possible to build an ACO that does not meet the triple aim. Hospital may buy up all practices yet price may still rise.
- Need to explicitly address the uninsured.
- What will a payer row look like?
  - Need to find another word for payer, as it does not mean the same thing for social service organizations that rely on a funding stream.
  - Need to align funding streams with payers.
  - Payer could be an integrator.
  - Payer should be an additional row on the straw proposal.

- A long-term goal is to address governance to ensure that there are multiple players
- Diabetes is a good example of alignment
- What barriers exist?
  - Assuming risk both up and downside.
  - At what point to organizations become a risk-bearing model OR is it necessary?
  - New requirements on the provider/ new measures.
  - Need to be sure to include requirements that many providers are already under, to become a Health Care Home, etc.
  - Need to learn from those that have dropped out from the Medicaid Plan in MN.
  - Need real communication and understanding by organizations on how to implement.
  - Liability and legality
  - How do you ensure that systems are talking; 80% are using Epic but they are using different versions?
  - Finance mechanism is a barrier if they are reliant on a Medicare system, which may reward critical access hospitals.
  - Who is accountable for a client who has seen multiple providers?

Questions to members:
- What combination/level is required to reach desired outcomes?
• How would your organization get to that destination?

Members mentioned the letter from ARChE.

Diane Stollenwerk shared information on a project she is working on with the National Quality Forum. 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: Vision and Goals
Diane Stollenwerk walked through member feedback on the vision and goals document, and highlighted some of the conflicting recommendations.

Diane Rydrych informed committee of next steps. The state received very rich feedback, 15 pages. Some were just wording changes but many were on much larger concepts that may or may not fit within this single document. The state will take more time to incorporate feedback and will bring a revised version of this document back to the task force in November.

Want to be sure to address those recommendations that may not fit in this document but could fit elsewhere.

The Vision and Goals document ties to the straw proposal and also the operational plan. The state will discuss this connection further in November.

Key Milestones – first year
Diane Rydrych walked through key milestones.
• The state is contracting with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, who will present initial ideas and gather feedback from the task force in November.
• Data alignment is a large part of the first year of the grant. The second year of the grant may be more technical assistance for providers and gathering feedback. The State will begin a discussion with the task force about potential alignment opportunities this winter.
• The baseline assessment will also be discussed in November; not sure at this time if the state will present initial ideas or just start the discussion.
• There will be no meetings in December. By March the committees will have moved to an every other month schedule.

Next Steps
Garrett provided information on homework and next meeting.
Members asked about the ARChE request to present to the committee at the November
Meeting.

- Marie Zimmerman responded that the state was developing a policy to ensure there is a process for members/organizations that wish to present to the task force. More information will be provided to the task force soon.

Public Comment

- Ken Joslin, Physician: Triple aim should be the quad aim in order to acknowledge how unhappy many providers are in the current system.
- Julie Gammon, pharmacist for Genowa Health Care, members must think of nontraditional providers. Mental health needs to be a focus. How will they work with smaller providers that may not be part of a larger group?
- Jen Olson, telehealth and board of aging, this is still very hospital centric. Many providers, home care, etc. can provide services that are not in a brick and mortar building. They know how to care for the critically ill.
- Virginia Barson, MN Academy of Physicians, MN professionals are investing also not just the state and payers.
- Linda Davis, personal, the $111M savings is payment to some organizations and this must be considered. There will be push back on some of these changes.