health reform MINNESOTA
A Better State of Health

Minnesota Accountable Health Model: Continuum of Accountability Matrix

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. This matrix is a tool to illustrate the basic capabilities, relationships, and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It is designed to assist the state in identifying criteria and priorities for investment, and to lay out developmental milestones that indicate organizations or partnerships are making progress towards the vision.

In this document, the terms 'organization' and 'provider' are meant to include a broad range of health and health care providers that may or may not formally be part of an existing ACO as defined by the Centers for Medicare and Medicaid Services (CMS) or other payers, but that are moving towards greater accountability for quality, cost of care and health of the populations they serve. Many types of organizations, including not only providers of medical care but also organizations that operate in the behavioral health, social services, local public health, long term care/post-acute care settings, community organizations, and other public/private sector partners that provide supportive services to individuals and families, can all have a role in convening, leading or participating in accountable health models at different stages of the continuum. As organizations or partnerships move from left to right on this matrix, the expectation is that the number, type and depth of provider-community partnerships increases and relationships become more formalized.

Stages of Accountable Care

The continuum of Accountable Health Models (also known as accountable care models or accountable care organizations) is represented by level A through level D.

- Level A characterizes an organization that has begun some delivery/payment transformation activities and has begun the process of forming system capabilities and/or partnerships to form an accountable care model or ACO. These organizations have little prior experience with integrated or accountable care models or related financial arrangements.
- Level B characterizes an organization that is starting to participate in a model under a framework of accountable care and payment arrangements, including initial use of data, data sharing and data analytics to provide treatment and coordinate care. In addition, this organization will develop and plan intervention strategies to improve health and lower cost.

- Level C characterizes organizations that have been participating in a model under a framework of accountable care and payment arrangements and are now expanding their quality, consumer experience, health outcome measurement, data analytics and sharing, engagement of communities, and reductions of health care expenditures, etc.
- Level D illustrates an accountable health model/community for health which represents partnerships or organizations using accountable care supported by innovative payment and care delivery models that integrate medical care, mental/chemical health, community health, public health, social services, schools and long term supports and services, and who have made a demonstrated commitment to continue to grow and develop this model of integration. This includes demonstration of a commitment to share accountability across partners.

While there are multiple examples of how an organization may achieve a level, this matrix describes minimum components that are likely to be necessary to demonstrate movement along this continuum. The State recognizes that transformation is not linear; organizations or partnerships may be at different levels of development on different issues, and the boundaries between levels may sometimes overlap. It is not necessary for an organization to have achieved Level C capabilities in all areas in order to be eligible for support or technical assistance under The Minnesota Accountable Health Model; the goal is to use The Minnesota Accountable Health Model supports to move organizations or providers onto this grid, or further to the right, in as many areas as possible.

For example, an organization may have achieved the Level C capabilities in terms of the health information technology or health information exchange, but still be working at Level A in terms of payment arrangements – or may be at pre-Level A stage on other issues. The Minnesota Accountable Health Model supports and resources are designed to move organizations and partnerships onto and along this continuum, with the ultimate goal of increasing the number of consumers in Minnesota who receive care within communities and from organizations that have all of these elements in place, but with a recognition that organizations may move along this continuum at different rates and use different approaches.

health reform MINNESOTA
A Better State of Health

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
Model Spread and Multi-Payer Participation Payer participation, % of total lives in model or % of revenue in performance-based or value-based payment (across payers) <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Develop community core measures for ACO cost and quality; establish ACO core competencies and regulatory structures 2. Align and evolve ACO payment methodologies	Care coordination fees received by entity, performance-based or value-based fees or incentive payments by most payers or significant % of payers; OR Less than 5% of total revenue from performance-based or value-based payment	Alternative types of payment arrangements with 1-2 payers that represent 20-50% of consumers; OR Between 5% and 15% of total revenue from performance-based or value-based payment	Alternative types of payment arrangement with 2+ payers that represents 50%+ of consumers; OR Between 15% and 30% of total revenue from performance-based or value based payment	Alternative types of payment arrangement for majority of payers/consumers; OR More than 30% of total revenue from performance-based or value-based payment	Reduce the per capita cost of health care

health reform MINNESOTA
A Better State of Health

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
Payment Transformation Types of Alternatives to FFS Payment Arrangement(s) <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Align and evolve ACO payment methodologies 2. Develop financial model and measures for integrated team-based models specific to complex populations 3. Develop a methodology or roadmap for incorporating ACH activities into payment models	Health care home or similar care coordination fees, quality improvement/incentive payments	Shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk (e.g. episode-based payments)	Shared savings and some arrangements moving toward risk sharing through Total Cost Of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization	Most arrangements include some level of risk, payment at or moving toward prospective or global payment; quality component of payment includes population health measures/ accountability; community partners are sharing in accountability for cost, quality and population health and included in the financial model in some form.	Reduce the per capita cost of health care

health reform MINNESOTA
A Better State of Health

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
Community Partnerships Types of provider and/or community partnerships <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Improve care delivery by providing resources/training on topics identified as providers as necessary for meeting goals for team-based, coordinated care 2. Expand the use of non-MD, innovative provider types (e.g. community health workers, community paramedics, dental therapists) within primary care practices 3. Establish & implement models for ACH	Informal relationships between health care providers and community providers or organizations through basic referrals	Informal and some formal agreements or arrangements between health care providers and community partners; may include common consent process, data-sharing, participation in a common activity or intervention (e.g. coordination of care for frequent ED visits, community care team focusing on specific chronic disease)	Formal partnerships between community providers or organizations with health care delivery provider/system (e.g. inclusion of social worker, community mental health provider, public health nurse, as part of the care team), inclusion of some other informal partnerships or arrangements (e.g. coordination/referral with schools, vocational, housing, correctional, transportation, parish nursing etc.)	Wide range of formal partnerships between community providers/organizations and health care delivery providers working collaboratively within a defined community to transform population health including coordination of care, collaboration on clinical and population health improvement activities, etc. leading to sustained improvements in broad population health metrics	Improve the consumer experience of care Improve the health of populations

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
Infrastructure to Support Shared Accountability Governance; types of business and financial arrangements <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Develop community core measures for ACO cost and quality**;** establish ACO core competencies and regulatory structures 2. Establish and implement models for Accountable Communities for Health	May only include a single organization with informal partnerships with other providers and organizations	Includes an informal or formal legal, contractual and/or financial arrangement between multiple independent organizations; may include informal partnerships or data-sharing agreements between health care providers and community partners.	Formal legal establishment of the accountable entity that can include the formation of new legal entity or a contractual agreement between organizations; includes decision-making, resource-allocation, shared care model/QI activities, data sharing; include an agreement with one or more community partner	Formal contractual or legal partnership agreement with a defined community that expands the accountable entity. These arrangements include decision-making, agreements on population health goals/strategies, shared governance, data-sharing, and some financial arrangements.	Reduce the per capita cost of health care Improve the consumer experience of care Improve the health of populations

health reform MINNESOTA
A Better State of Health

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
Health Information Technology – Electronic Health Record Adoption and Effective Use <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Increase Electronic Health Record adoption among behavioral health, long-term care, local public health, and social services providers via technical assistance and the development of roadmaps and tools/resources 2. Improve population health interventions by enabling state agencies to engage in secure health	EHR in place or organization plans to implement an EHR by specified date. EHRs should either be certified by the Office of the National Coordinator (ONC) pursuant to the Federal Health Information Technology for Economic and Clinical Health (HITECH) Act or a qualified EHR as defined in Minnesota Statute 62J.495.	Providers are beginning to optimize their system for effective use, including developing the capacity to do: – clinical decision support – provider order entry	Providers develop capabilities (including workflow, organizational policies, training/workforce) in place to support effectively use of their EHR system for: – clinical decision support – provider order entry – capture and query information relevant to health care quality – Incorporate clinical lab test results as structured data – Supporting transitions of care, population health and quality improvement – Allow patients or their	Widespread adoption of EHR and other HIT that can provide accountable care-related processes and functions, across all organizations and settings within partnership, including participating community partners. EHRs are used to provide additional comprehensive functions such as: – care coordination – cohort management, – consumer and caregiver relationship management, – clinician engagement – financial	Reduce the per capita cost of health care Improve the consumer experience of care Improve the health of populations

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
information exchange with providers			representatives access to view online, download and transmit their health information Meets the EHR functional requirements of Minnesota's 2015 mandate for interoperable electronic health records (Minnesota Statute 62J.495)	management, reporting – Knowledge management. – Continuous quality improvement	
Health Information Exchange - Capabilities using National Standards <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Increase the number of communities and providers (including behavioral health,	"Push" capabilities (the ability to send or receive Direct secure messages are established with at least one unaffiliated partner.	Minimum use cases essential for health information exchange are identified, including (when appropriate): – Electronic prescribing (as required by Minnesota Statute 62J.497)	Pull/query capabilities (the ability to securely query for consumer information from multiple locations) are established with multiple unaffiliated partners across care settings, for some use cases	Pull/query capabilities (the ability to securely query for consumer information from multiple locations) are established with multiple unaffiliated partners for multiple use cases, including with community partners	Reduce the per capita cost of health care Improve the consumer experience of care

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
long-term care, local public health, and social services providers) using secure Health Information Exchange (HIE) via community collaborative grants and technical assistance		– Public health transactions – Laboratory data transactions – Quality reporting transactions – Transfer of care and referral summaries Meets the interoperability requirements of Minnesota's 2015 mandate for interoperable electronic health records (Minnesota Statute 62J.495)			Improve the health of populations
Data Analytics Capabilities <u>Minnesota Accountable Health Model Objectives & Activities:</u> **1.** Enable ACOs to better manage patients and	Use of consumer registry or other data warehousing to identify and/or stratify populations (i.e. populations with certain risk factors),	More formal reporting and sophisticated performance reporting for quality improvement (QI), health improvement	Ability to integrate and use in reporting some or all administrative claims data and clinical data into a single data infrastructure; ability to analyze and report	Expanded level of data reporting including integration and analytics with multiple community partners, or inclusion of consumer and population data	Improve the consumer experience of care

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
total cost of care by providing enhanced data analytics, reporting and technical assistance	performance reporting for some QI activity within a single organization	activities, cost, and coordination for defined population (ex. consumers with multiple chronic conditions.) May be beginning to develop internal analytic capabilities or employing a vendor	on cost, clinical and quality indicators in more sophisticated or granular ways (ex. for multiple populations based on risk factors, episodes of care, disease status, psychosocial determinants, product participation and geography). Provides some level of data reporting to a community partner(s)	from community partners in registries/ databases for QI, care coordination, and population health	Improve the health of populations
Health Care Delivery and Community Services Integration and Coordination -Medical/primary care/specialty care, sub-acute -Behavioral health -Long-term care services and supports/post-acute	Coordination and integration of health related activities within a single organization (e.g. care coordinator sits within clinics or is co-located), may include some co-location or consultation with other providers or	Greater coordination and integration of services between providers, across settings and community organizations (e.g. shared health or care plan, formal consent processes, shared responsibility in	Health teams that extend beyond a single provider organization to include some formal model of bi-directional care coordination/ management, or health improvement with community partners (e.g. primary and behavioral health,	Care coordination and health improvement activities includes broad range of services and populations (including post-acute care, social services, and behavioral health), and includes formal relationships between providers and multiple	Improve the consumer experience of care Improve the health of populations

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
care -Social services -Public health/prevention -Other public/private sector or community services <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Improve the quality of primary care delivery by providing direct provider support/TA for practice transformation/transition to team-based, patient centered coordinated care 2. Expand the use of non-MD, innovative provider types (e.g. community health workers, community paramedics, dental	organizations	intervention, care management, or health improvement activities for consumer population/sub populations)	parish nursing), multi-disciplinary health teams embedded in "hub" or single organization, health teams and community services/organization have formal connection/partnership	community organizations to identify coordination and health improvement barriers and strategies, develop population health improvement goals and metrics.	

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
therapists) within primary care practices 3. Improve care delivery by providing resources/training on topics identified as providers as necessary for meeting goals for team-based, coordinated care					
Patient-Centeredness <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Improve the quality of primary care delivery by providing direct provider support/TA for practice transformation/transition to team-based, patient centered	Principles of patient-centered care that include family and cultural values and preferences are included in the organization's vision and mission statement	Principles of patient-centered care that include family and cultural values and preferences are a key organizational priority and included in training and orientation for all employed and contracted staff	Principles of patient-centered care that include family and cultural values and preferences are explicit in job description and performance metrics for all staff and providers and incorporated into planning and organization of care	Principles of patient-centered care that include family and cultural values and preferences are systematically and consistently used to guide organizational changes, plan care delivery and measure system performance as well as care interactions at the	Improve the consumer experience of care

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
coordinated care 2. Improve care delivery by providing resources/training on topics identified as providers as necessary for meeting goals for team-based, coordinated care				practice level.	
Patient/Consumer Input and Patient Engagement <u>Minnesota Accountable Health Model Objectives & Activities:</u> 1. Improve the quality of primary care delivery by providing direct provider support/TA for practice transformation/transition to team-based, patient centered coordinated care	Patient/consumer input is accomplished using a patient satisfaction survey administered sporadically at the organization or enterprise level.	Patient/consumer input is accomplished through regularly soliciting patient input through patient experience surveys at the clinic or department level. Results are shared with care teams and acted on.	Patient/consumer input is accomplished by getting frequent input from patients and families using a variety of methods, including surveys, point of care information, focus groups or participation on patient advisory groups.	Patient/consumer engagement is accomplished by getting frequent and actionable input from patients and families who actively participate on interdisciplinary quality improvement and other advisory teams that provide meaningful opportunities for input into quality improvement.	Improve the consumer experience of care

Proposed Program Components	Proposed Expectations by Level for Continuum of Accountable Health Model				Triple Aim Goal
	Level A – Beginning	***Level B – Progressing***	***Level C - Intermediate***	***Level D – Advanced***	
2. Improve care delivery by providing resources/training on topics identified as providers as necessary for meeting goals for team-based, coordinated care			Patient/consumer input tools are available in multiple languages to reflect populations served.	Patient/consumer input tools are available in multiple languages to reflect populations served.	
Services Included in Model (delivery and payment) <u>Minnesota Accountable Health Model Objectives/Activities</u>: **1.** Develop financial model and measures for integrated team-based models specific to complex populations	Services directly provided or immediately impacted by one organization/sector (e.g. just medical or LTSS)	Accountability for a defined set of services for "whole person" within a sector or part of care continuum (e.g. primary/acute care or long-term care only), regardless of where the services are delivered	Accountability for "whole person" expands to include other sectors, including behavioral health (either mental health and/or chemical dependency) and/or long-term care services and supports	Accountability at some level of population health including: all health care, behavioral health and LTSS within a defined community; accountability may be shared to varying degrees for population health including metrics and cost. Identified community services included as part of a model that leads to health improvement for identified broad metrics.	Improve the consumer experience of care Improve the health of populations