EXECUTIVE SUMMARY

FINAL

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Prepared for:
Minnesota Department of Human Services
Minnesota Department of Health

Prepared by:
State Health Access Data Assistance Center (SHADAC)
EXECUTIVE SUMMARY

The State Innovation Model (SIM) Program is sponsored by the Centers for Medicare and Medicaid Services (CMS) and administered by CMS’s Center for Medicare and Medicaid Innovation (CMMI). SIM provides funding and support to states to transform their public and private health care payment and service delivery systems with the aims of lowering health system costs, maintaining or improving health care quality, and improving population health. In 2013, Minnesota received a SIM award to implement and test the Minnesota Accountable Health Model. Between October 2013 and December 2016, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) are implementing the Model across the state of Minnesota.

This document summarizes a separate full report of the activities conducted during and the results from the first year of an evaluation of Minnesota’s SIM initiative. The State Health Access Data Assistance Center (SHADAC) is conducting the state evaluation under a contract with DHS and in collaboration with both DHS and MDH.

Introduction

The Affordable Care Act of 2010 (ACA) established CMMI within CMS as a vehicle to test payment and service delivery models. This was to be achieved through pilot programs that were designed with the goals of lowering costs for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) while maintaining or improving the quality of care for beneficiaries.

Sponsored by CMS, the SIM initiative is a major program administered by CMMI that provides grant awards and support to states to design and/or test innovative and multi-payer health care delivery and payment reforms. In 2013, Minnesota was one of six states to receive a three and a half year SIM award to advance and test the Minnesota Accountable Health Model. The model builds upon the state’s previously established Medicaid Accountable Care Organization (ACO) demonstration projects and other payment and delivery reform efforts including Health Care Homes (HCH), the e-Health Initiative, Community Care Teams (CCTs), the Statewide Health Improvement Program (SHIP), Community Transformation Grants, and standardized quality measurement and reporting across payers.

Under the Minnesota Accountable Health Model, Minnesota has four aims for the state’s health care system:

- The majority of patients receive care that is patient-centered and coordinated across settings;
- The majority of providers are participating in ACOs or similar models that hold them accountable for costs and quality of care;
- Financial incentives for providers are aligned across payers and promote the Triple Aim goals;

1SHADAC. Evaluation of the Minnesota Accountable Health Model: First Annual Report. The Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH), April 2016. This program is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.
• Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals.

The activities that work towards these goals are organized into five primary drivers:

1. The expansion of e-Health;
2. Improved data analytics across the State’s Medicaid ACOs (i.e., Integrated Health Partnerships [IHPs]);
3. Practice transformation to achieve interdisciplinary, integrated care;
4. Implementation of Accountable Communities for Health (ACHs); and
5. Alignment of ACO components across payers related to performance measurement, competencies, and payment methods.

Key mechanisms the state is using to execute this work are grants and contracts, technical assistance, and other resources for providers and other organizations in the state.

Evaluation of the SIM Initiative

CMMI is requiring two levels of evaluation of the SIM initiative: 1) a federal multi-state evaluation and 2) individual state evaluations. In fulfillment of CMMI’s evaluation requirements, DHS issued a contract with SHADAC to perform a formative state-level evaluation of the Minnesota Accountable Health Model, conducted in collaboration with both DHS and MDH. The goals of Minnesota’s state evaluation are to: 1) document activities under the Model; 2) document the variation in design, approach, and innovation of those activities; 3) identify opportunities for continuous improvement; 4) examine how the program has contributed to advancing the state’s goals; and 5) identify lessons learned for program sustainability. These goals are applied to each of the five primary drivers.

The full state evaluation report, on which this Executive Summary is based, presents the activities conducted during and the results from the first year of the evaluation of the Minnesota Accountable Health Model. The evaluation draws upon both quantitative and qualitative methods and both existing and new data sources. Key evaluation data in 2015 included a database of organizations participating in SIM activities; semi-structured qualitative interviews with over 200 individuals engaged in the reform efforts including state leaders and staff, grantees, and contractors; systematic reviews of state, grant, and contract materials; and the Minnesota Accountable Health Model Continuum of Accountability Assessment Tool, a survey designed to assess providers’ and organizations’ capabilities with respect to accountable care.

The full report includes a presentation of the investments Minnesota has made under the SIM initiative and individual chapters on Minnesota activities and key findings through 2015 in the areas of e-Health (Driver 1), ACOs (Drivers 2 and 5), investments in team-based, integrated/coordinated care (Driver 3), and ACHs (Driver 4). The report closes with a discussion of progress, gaps, and considerations for sustainability across all SIM investments in the state as well as appendices providing supporting and more detailed information. This Executive Summary highlights key information from the full report.
Overview of SIM Investments

Supporting the scope of the Minnesota Accountable Health Model has required considerable investments in creating a specific governance and management structure as well as mechanisms for engaging stakeholders throughout the state. Additionally, since receiving the SIM award in 2013, the state has invested over $25 million by issuing over 29 contracts and awarding 111 grants.

To operationalize the state’s vision, DHS and MDH established a cross-agency organizational governance structure, which included: an Executive Committee providing strategic direction and decision-making; a Leadership Team responsible for day-to-day project oversight and management; and three core workgroups in charge of executing components under the five primary drivers. The various stakeholders of Minnesota’s Model outside of state government include medical providers, payers, advocacy groups and the state’s four priority setting providers (behavioral health, long term/post-acute services and support, local public health, and social services).

Minnesota has been working to engage external stakeholders through a multifaceted approach that has included creating two Task Forces, convening regional meetings, and performing communications activities. To support and provide guidance for the state teams implementing the Minnesota Accountable Health Model, two external Task Forces were established (a Community Advisory Task Force and Multi-Payer Alignment Task Force) and have convened 15 times each between July 2013 and December 2015. Representation on these Task Forces includes payers, providers, various care settings, and a consumer. The Community Advisory Task Force is responsible for advancing community and patient engagement across the continuum of care, and the Multi-Payer Alignment Task Force supports alignment across payers as well as the development of ACOs. Additionally, two Task Force subgroups were formed: the Community Advisory Task Force formed the ACH Advisory Subgroup in the winter of 2014 to provide guidance on strategies to engage stakeholders and communities in ACH planning. A Data Analytics Subgroup also exists to develop recommendations to promote consistent sharing of data analytics reports between payers and providers that are part of ACO models such as the IHPs.

During 2015, the Data Analytics Subgroup work was divided into two phases. Phase 1 focused on the current data analytic environment and possible immediate improvements in alignment of data analytic reports used by payers with the providers that they contract with in ACO or similar arrangements. The Phase 1 subgroup identified five high priority data elements in their final report where greater alignment would be beneficial, including: 1) contact information and identified primary care provider; 2) health status and risk level; 3) total cost of care (TCOC); 4) health status, grouped by demographics; and 5) patterns of care within and outside of ACO providers. This work was institutionalized, in part, by the Administrative Uniformity Committee (AUC), a voluntary group working to improve health care administrative processes in the state. In September 2015, the AUC voted to establish a Technical Advisory Group to address the need for consistent contact information and identified primary care provider data elements across payers. Phase 2 of the Data Analytics Subgroup is now underway and is focusing on social determinants of health data components.

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To inform, educate, and attempt to attain stakeholder buy-in for the Minnesota Model across the state, three waves of regional and open community meetings have been held by (and on behalf of) the state. For the communications component of the state’s engagement strategy, the Leadership Team has collaborated with MDH and DHS communications staff to update Task Force members and leadership; hold public events (e.g., webinars and presentations); and manage a website, a monthly newsletter, and social media presence. With Task Force input, the state also invested resources to develop and require all organizations applying for grant funding under the Minnesota Accountable Health Model to complete a Continuum of Accountability Assessment Tool. The tool allows organizations to self-assess their status on 31 capabilities and functions related to participation in accountable care models and the Triple Aims of improved care, improved population health, and lower health care costs.

Through the state’s contracts, grants, and engagement efforts, a wide variety of organizations have been participating in the Minnesota Accountable Health Model throughout the state, either as vendors, partner organizations, or fiscal agents (recipients of the grants and contracts and sometimes acting as lead organizations). The following summarizes the makeup of these 424 organizations:

- Among the participating organizations, 27% are traditional medical providers, 45% are priority setting providers, and 28% are other types of organizations;
- The organizations represented also reflect the collaborative nature of the initiative, with 160 organizational partners and vendors in the e-Health collaborative grants and 214 participants in the 15 ACHs as examples;
- With respect to geographic locations, while there are participant organizations across the state, about 67% are located in urban counties;
- Organizations have been able to interface with the SIM effort in multiple ways, as there are also 104 organizations that are involved with at least two programs.

**E-Health**

With several laws passed in the past decade supporting the use of electronic health information, Minnesota has consistently ranked as one of the states with the highest rates of hospital and ambulatory clinic electronic health record (EHR) adoption in the country. However, there is recognition that a crucial next step requires moving beyond simply adopting EHRs. Interoperability—the seamless, bi-directional communication across settings—will be necessary to fully realize the benefits of leveraging electronic health information. For Driver 1 of the Minnesota Accountable Health Model (e-Health), the state’s funding has supported three areas of e-health investment:

- Minnesota Technical Assistance and Education: Privacy Security and Consent Management;
- Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model;
- Minnesota Accountable Health Model e-Health Grant Program (“e-Health Collaboratives”).

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As work on the Privacy, Security, and Consent Management (PSCM) only began in July 2015, this document focuses on the latter two areas, the e-Health Roadmap and e-Health Collaboratives.

**E-Health Roadmap**
The goal of the e-Health Roadmap is to advance each of the four SIM priority settings’ progress in adopting and using EHR and health information exchange (HIE). The project, which began work in January 2015, is a collaborative effort led by the MDH’s Office of Health Information Technology and Stratis Health. The 18-month grant program is being conducted in three phases: planning, development, and education. To date, the first phase is complete, the second phase is in progress, and work is underway for phase three.

Key activities have included:

- Recruitment of participants from across the care spectrum to engage in several ways: as a subject matter expert, a member of a community of interest, a member of one of four priority setting workgroups, and/or a member of the steering team;
- Development of a shared understanding of the project and identification of common terms among the four settings;
- Identification of use case stories (based on real experiences) that highlight the need for better exchange of electronic health information; and
- Ranking the use case stories based on criteria developed by each workgroup based on their respective populations.

The following findings related to these efforts were identified through review of program reports, meetings, and interviews with state staff and grantees.
E-Health Roadmaps - Key Findings

Early Outcomes

- Stakeholders from across the care continuum were effectively engaged in various capacities.
- Participants saw the benefits of developing compelling patient use case stories.
- Stakeholders witnessed an evolving definition of “Roadmap.”
- Similarities across the use cases developed by priority setting led to the decision to produce one roadmap.

Facilitators

- Stratis Health leveraged its existing relationships with intended stakeholders.
- Several stakeholders had experience with previous e-Health initiatives.

Challenges

- Intense communication needs were not clearly expressed in the request for proposals.
- Federal contracting requirements related to the unrestricting of funds introduced delays.

Sustainability Insights

- There is a lack of funding for Roadmap implementation, which raises concerns about future work.
- The lack of data standards for the electronic exchange of non-clinical information creates practical barriers to sharing data across settings.

E-Health Collaboratives

The goal of the e-Health Collaboratives is to support the secure exchange of information across health settings for the purpose of more effective care coordination. Eligible applicants of the grant program were not individual organizations but collaboratives that had at least two or more organizations participating in, or planning to participate in, an ACO or similar health care delivery model. Collaboratives were also required to include a partner organization from at least one of the four priority settings. Currently, there are 13 collaboratives across the state that have received the development grant (planning) and/or the implementation grant over two rounds of grant funding totaling $4.9 million.

The focus of this document is on the activities and findings from Round 1 collaboratives (six development and six implementation), as the work of Round 2 collaboratives began in the fall of 2015. Key activities completed by e-Health Collaborative grantees included:

- Organizational readiness assessments for HIE;
- Extensive communication and education activities to keep project partners engaged and active in the process;
- Addressing governance, legal, policy, and business operational issues;
- Assessment of privacy and security issues;
- Care coordination model development and identification of how HIE would support that model;
- Preparation for data sharing and (in some cases) development of standards for non-clinical data sharing; and
- Evaluation and selection of a HIE service provider.

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Key findings (presented below) focus on the insights observed from these activities and draw upon grantee reports to the state and interviews with the state staff and participants from all 12 of the Round 1 e-Health Collaboratives.

### E-Health Collaboratives Grant Program - Key Findings

#### Early Outcomes
- The funding served as a catalyst for collaborative members to discuss how to use HIE to coordinate care in a structured way and provided an opportunity to learn about how HIE could expand their capabilities.
- Meetings provided the space and time to understand complexities and challenges faced by other organizational partners; this promoted the formation, or deepening of, organizational partnerships.
- Grantees were able to leverage the grant to create additional opportunities for partnerships and funding.
- Two organizations (Fergus Falls Community of Practice and Southern Prairie Community Care) reported success in exchanging some type of electronic information across settings.

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<tr>
<th>Facilitators</th>
<th>Challenges</th>
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<tr>
<td>Project plans that were aligned with an organization’s strategic plan and championed by senior leadership enabled project staff to successfully achieve project milestones.</td>
<td>There has been a lack of understanding regarding what HIE actually entails.</td>
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<td>A dedicated project management lead oversaw logistics and communications tasks.</td>
<td>Many grantees had insufficient internal staff resources to manage grant activities, especially ongoing communication and education needs.</td>
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<td>Face-to-face interactions among project partners facilitated shared understanding.</td>
<td>Collaboratives underestimated the time and resources required to establish a governance structure and to address strict state data privacy laws.</td>
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<td>Using the promise of future data analytics capabilities encouraged participation.</td>
<td>Organizations had varying capacity to implement HIE through their existing EHR systems.</td>
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<td>Setting small, achievable goals built momentum, and the state has been flexible and open to communication with respect to adjusting goals/objectives.</td>
<td>Addressing workflow issues was a major obstacle for several grantees trying to implement HIE protocols.</td>
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<td>Grantees encouraged addressing governance issues and finalizing care coordination models before deciding on technology/vendor solution.</td>
<td>Grantees struggled to identify capable HIE service providers because of communication issues or insufficient capabilities.</td>
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<td>Reconsider establishing a single statewide HIE entity.</td>
<td>There was a conflict between grant program goals and the perceived limitations of Minnesota’s HIE.</td>
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<td>Support the development of an infrastructure for shared data services.</td>
<td>Allow for state certification of federally certified HIE providers.</td>
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<td>Allow for technology vendors.</td>
<td>Consider creating stronger economic incentives/mandates for data sharing.</td>
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### Policy Considerations
- The high costs of HIE investments are a barrier to the sustainability of HIE implementation work.
- Incentives from participation in shared savings programs facilitate the expansion of HIE capabilities.
- Some grantees are concerned about the state’s ability to achieve true statewide data exchange.
- The lack of funding for care coordination work hinders the usefulness of HIE capabilities.

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ACOs

Fundamental to the Minnesota Accountable Health Model are ACOs, provider delivery systems that manage the health care needs of a defined population through performance and financial incentives. Prior to the SIM effort, Minnesota’s Medicaid ACO demonstration—developed initially as the “Health Care Delivery Systems (HCDS) demonstration”—attempted to create more cost-effective care in fee-for-service (FFS) delivery systems and create new options for Medicaid providers to participate in shared savings programs. The program has since been renamed to the Integrated Health Partnerships (IHP) demonstration, and the number of participating delivery systems has expanded.

Though the IHP program was initiated prior to the Minnesota Accountable Health Model, Drivers 2 and 5 under the Model are meant to accelerate the program. Driver 2 (IHP data analytics) and Driver 5 (alignment of ACO components) both pertain to the advancement of ACOs in Minnesota and have been translated into four key investments by DHS and MDH:

- Enhanced reporting to Medicaid IHPs;
- Technical assistance to IHPs in the area of data analytics;
- Data analytic grants to IHPs; and
- The ACO baseline assessment, a survey and qualitative interviews of providers and payers about the scope and characteristics of existing ACO arrangements in the state.

Integrated Health Partnerships

There have been three rounds of IHP entrants since 2013, and IHPs are located across the state, though most are in the Twin Cities area. Key activities and findings reported below are based on interviews with executives, administrators, and clinicians from the 15 of the 16 IHPs as well as state program staff. It should be noted that IHP data analytics grants and technical assistance activities were just getting underway at the time of these interviews, and the discussion of the state’s ACO baseline assessment has already been well-documented.² SHADAC identified examples of IHP program activities, which include:

- IHP development of clinical strategies and/or strategies of integrating nontraditional services from other priority settings;
- DHS production of standard data packages derived from Medicaid claims data to help IHPs better understand resource use and identify areas for targeted interventions;
- IHP development of relationships with community organizations in a variety of ways, both formal and informal; and
- IHPs strategies related to physician engagement.

Integrated Health Partnerships - Key Findings

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<th>Early Outcomes</th>
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<tr>
<td>• The IHP program has expanded and includes new ACO models.</td>
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<td>• Data analytics facilitated IHP learning and planning for the populations they serve.</td>
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<td>• The IHP program and associated savings potential have encouraged IHPs to make investments in clinical models and supporting data infrastructure with a population health orientation.</td>
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<th>Continuous Improvement Feedback</th>
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<td>• State IHP data and reporting were valuable, but data gaps and barriers remain with respect to how to use the state data most effectively.</td>
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<td>• IHPs were uncertain how to leverage the support available from the technical assistance contractor.</td>
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<th>Sustainability Insights</th>
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<td>• There is a lack of clarity on how the IHP program and managed care system will interact and evolve in the future.</td>
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<td>• There are concerns about the ability to generate savings when total cost of care (TCOC) benchmarks are recalculated.</td>
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<td>• There is a disconnect between the retrospective attribution model and clinical quality improvement.</td>
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<td>• IHPs are not always clear which factors allow them to replicate success.</td>
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<td>• Some delivery systems expected the overall movement toward value-based purchasing would have been quicker and suggest there may not be enough revenue at risk within ACO-type arrangements.</td>
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Team-Based Integrated/Coordinated Care

The three goals of Minnesota’s 2008 state health reform legislation were to improve the health of the population, the patient experience of care, and the affordability of health care. The MDH HCH initiative is one of the vehicles for the Triple Aim. The HCH initiative is a voluntary program in which practices and providers, after meeting a rigorous set of certification standards, become eligible for receiving monthly per-person payments for care coordination activities.

The Minnesota Accountable Health Model builds on the infrastructure and momentum of the existing HCH program. The goal for the state’s SIM funding under Driver 3 is to expand the number of patients served by team-based, integrated, coordinated care. Efforts in service of this goal include investments in infrastructure, the development of implementation supports and quality improvement activities, support for integrating providers from emerging professions, and support for practices seeking certification or re-certification as HCHs or Behavioral Health Homes (BHHs)—the BHH model is part of DHS’ initiative to integrate primary care and behavioral health services for Medicaid enrollees. These efforts are carried out through five grant programs:

- Emerging Professions Integration;
- Emerging Professions Toolkits;
- Learning Communities;
- Practice Facilitation; and
- Practice Transformation.

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Due to the timing of these grants, this document’s findings focus on Round 1 of the Practice Transformation grant program and were based on in-person and/or phone interviews with grantees at or near the end of their grant periods.

**Practice Transformation**

Round 1 Practice Transformation grants totaled nearly $200,000, which funded four primary care, four behavioral health/social service, and two combined primary care and behavioral health organizations throughout the state. Key activities included:

- Preparation for HCH certification or recertification;
- Sharing of information across providers, patients, locations, and time frames to enhance care coordination;
- Supports for integration of primary care and behavioral health;
- BHH planning; and
- Patient registries and data analytics capacity building.
### Practice Transformation Grants - Key Findings

#### Outcomes
- Grantees were successful in becoming HCH certified or re-certified.
- Care coordination was enhanced, as grantees reported improved communication between providers, care coordinators, and health educators; revised staffing and position duties to facilitate work at the top of the license; more patient referrals to health coaches, dietitians, and other specialized services; increased number of patient concerns addressed in a visit; and improved discharge planning and post-hospitalization care for patients.
- There were examples of primary care and behavioral health providers working together towards care integration.
- Grantees made progress in planning for BHH implementation.
- Grantees expanded existing patient registries and enhanced data collection processes and analytic capacity.

#### Facilitators
- The grant afforded provider and staff time to focus on practice transformation planning and implementation work.
- Committed and flexible leadership supported grant activities and aligned with organizational goals.
- Access to external expertise provided guidance related to internal processes, workflow changes, and technology enhancements.
- Communication among multiple stakeholders facilitated greater understanding of roles across departments and teams.

#### Challenges
- Existing EHR systems required significant resources, the systems varied across providers, and there was a lack of understanding of how to use the systems.
- There was staff turnover which caused delays in implementation, as well as hiring challenges, particularly in rural areas.
- Some grantees experienced reluctance from staff in adopting new processes.
- A few grantees suggested there were limitations of what activities were allowable with the grant funding.

#### Continuous Improvement Feedback
- The state’s flexibility allowed grantees to revise work plans due to unforeseen changes.
- Several grantees reported that these small grants enabled incremental, lasting changes.
- Learning opportunities provided by the state were beneficial, though IT assistance would have been helpful.

#### Sustainability Insights
- Where grant funding was used to develop new or refine existing processes, these changes have been incorporated into daily work; many grantees also sought additional grant funding.
- The ongoing HCH infrastructure, tools, and maintenance of certification and the impending BHH will serve as sources of sustainability for the practice transformation gains.

### ACHs

Prior to the establishment of the Minnesota Accountable Health Model, MDH administered the CCT Pilot (2011-2012), which provided grant awards to health care providers to improve existing partnerships of local hospitals, primary care clinics, public health, behavioral health, social services, and other community services that focused on a specific target population. Today, Driver 4 of the Model, Accountable Communities for Health (ACHs) builds on the experiences of the pilot. ACHs are community collaboratives comprised of providers and other organizations that employ care coordination and population-based prevention strategies to address the health care needs of a specific community population, with an emphasis on the needs of marginalized or underserved communities.
The key effort under Driver 4 has been the implementation of a two-year competitive grant program (January 2015 – December 2016) to establish 15 ACH grants, each receiving approximately $370,000. Three of the 15 ACHs were prior CCT grantees and received sole source grants for the ACH program. Two of these CCTs changed their activities and/or their target populations when they began their ACH work.

In addition to individual ACH grants, another grant, the ACH Learning Collaborative, was awarded to the National Rural Health Resource Center to support ACHs through provision of technical assistance and peer learning opportunities.

**Accountable Communities for Health**

Each ACH involves 5 to 20 organizations from a community, including at least one organization participating in an ACO model. ACHs must also include in their governance structure people who live in the community and organizations that represent the target population. Examples of patients/community members of focus include people with disabilities in the Metro area, adults using multiple prescription opioids in Morrison County, adults with a serious mental illnesses living with co-occurring chronic diseases in the Metro area, correctional facility clients in the Metro area, at-risk youth in crisis in northern rural counties, Latinos and East Africans with diabetes in Stearns County, and chronically ill adults in Rochester.

While all ACHs involve multiple providers, organizations, and individuals, the grant mechanism requires a lead agency. For almost half of the ACHs, the lead agency for the grant is (or is affiliated with) a health care provider such as health center, clinic, or hospital. Other lead agencies include a social service agency, a behavioral health provider, a managed care program, a health plan, an organization representing a multiple county health collaborative, county public health agencies, and a private foundation.

SHADAC’s findings are based on grant program materials, grantee reports, and interviews with individuals engaged in each of the 15 ACHs (a total of 102 individuals). Interviews with ACHs focused particularly on the design and implementation of their leadership structures and governance as well as their care coordination approaches.
Key ACH activities in 2015 included:

- Establishment of the ACH governance structure, including the formation of a leadership group and care coordination system or team;
- Identification of roles for participating partners, such as lead agency, ACO partner, local public health entity, and members of the community or the target population including patients and their caregivers;
- Design and implementation of a care coordination model or approach, including the locus and intensity of care coordination, personnel, outreach to patients and providers, needs assessments and care plans, data sharing, communication, referrals, and team-based care;
- Participation in the ACH Learning Collaborative; and
- Progress with other grant activities, including population-health prevention work, measurement/monitoring, and sustainability planning.
Accountable Communities for Health - Key Findings

### Early Outcomes

- Nearly all ACHs considered the formation of new partnerships and strengthening of existing partnerships one of their most important accomplishments of the first year.
- These partnerships have increased providers’ and organizations’ knowledge of existing resources, other areas of expertise, and a broader system of care to address the health and social needs of community members and patients. Most ACHs made the connection between this knowledge and improvements in the services they provide.
- About half of the ACH grantees communicated an increase in their awareness and understanding of the experiences and health and social needs of their community members and patients.

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<th>Facilitators</th>
<th>Challenges</th>
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| - ACHs benefited from previously established organization partnerships, infrastructure, and resources.  
- There has been an expressed commitment and desire to address the particular health concerns within the communities, as well as involvement of community members and members of the target population.  
- Having a strong, central project manager has facilitated project progress, in addition to staff shared across organizations.  
- Flexible and committed leadership within participating organizations was considered by multiple ACHs as key in the face of constraints. | - Federal contracting requirements related to the unrestricted of funds introduced delays at the start of ACH implementation.  
- For some ACHs, there has been difficulty in engaging organization partners, community members, and/or the target population. Regarding community participation, an early barrier stemmed from CMMI’s initial funding restrictions.  
- Navigating between organizational structures and siloed service areas slowed inter-organizational understanding.  
- In addition to gaps in the availability of certain services (especially in rural areas), hiring and retaining staff has been difficult.  
- It has taken time to develop a strong understanding of new care coordination roles.  
- ACHs have faced challenges related to data privacy and sharing data across organizational partners.  
- There have been insufficient resources for the non-clinical needs of patients and community members (e.g., financial assistance, housing). |

### Continuous Improvement Feedback

- State ACH coordinators were considered trusted and responsive resources.
- ACHs requested more targeted technical assistance and peer-to-peer learning related to interprofessional team environments, data integration and sharing, data privacy, data analytics/measurement/evaluation, reimbursement/billing, sustainability, and using data to make the case for potential funders.
- Individual ACHs called on the state to provide guidance, tools, or templates to ACHs for common tools being developed by multiple ACHs (to reduce unnecessary duplication) as well as additional opportunities for ACHs to share resources they are developing.

### Sustainability Insights

- Lessons from the CCTs, the early implementer ACHs, suggest that strengthened partnerships and capacity building can continue following the end of grant funding.
- Key sustainability concerns include current funding options and reimbursement levels for care coordination and for a central point person or project manager who coordinates and maintains collaborative efforts.
- Some ACHs are positioning their collaboratives for additional alliances and funding opportunities.

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Discussion
In this discussion, we present key findings from the state evaluation of the Minnesota Accountable Health Model to date. We summarize progress made under the Model as well as key gaps and challenges that persist. This section also provides input and feedback for improvement of SIM in its final year and highlights key issues for the state as it continues its strategic planning for sustaining the Model beyond the SIM award.

Findings
Progress
Overall, grantees conveyed their organizations’ enthusiasm and support for HIE, practice transformation, and collaborative approaches to population health as well as emphasized the importance of the SIM initiative in providing the impetus, resources, and time to develop and implement improvements within their organizations and communities. Our results through 2015 indicate that progress has been made toward the aims of the Minnesota Accountable Health Model, particularly with regard to provider participation in Medicaid ACO models, patient-centered and coordinated care across settings, and community collaboratives focused on clinical and population health.

- The IHP program has expanded and includes new ACO models.
- A key accomplishment of the SIM initiative has been the engagement of and the strengthening of relationships among a diverse set of stakeholders including health care providers, behavioral health providers, long-term/post-acute care services and supports, social services, and community organizations. State leaders view the SIM initiative as a catalyst for engagement and a broader conversation about health and health reform in the state.
- There was substantial knowledge transfer across organizations and sectors related to existing resources, areas of expertise, and broader systems of care to address the health and social needs of community members and patients. SIM participants reported that this knowledge has helped providers relate to patients/clients, strategically develop care plans, and connect to resources available in a community.
- Providers and organizations increased their awareness and understanding of their patients’ and communities’ health and social needs.
- Providers and organizations have advanced discussions related to HIE, exposing HIE priorities, gaps, and capabilities.
- Some areas of organization-level transformation under SIM have been institutionalized as part of the everyday operations of providers and organizations.

Gaps and Challenges
In the midst of the progress described above, several key gaps and challenges persist under the Minnesota Accountable Health Model.

This program is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.
Overall, adoption of value-based purchasing in the market has been slower than anticipated. In light of this and the fact that important questions persist about the payers and providers involved in ACO models and the nature of these arrangements, state efforts under SIM to develop quality measures, core competencies, and aligned payment methodologies for ACOs have also been on a slower timeline than originally planned.

There has not been much traction in the integration of non-medical providers in ACO arrangements. Most IHPs described partnerships with community organizations that are informal, with no financial commitment or binding language between organizations. Further, when asked about the relationship between their ACO attributed population and ACH target population, most ACHs reported that there is likely an overlap between the two but that an explicit link with the ACO population is not happening or is unknown to date. A few of the ACHs mentioned an inability to identify IHP patients who may be good candidates for ACH services. These ACHs called attention to a number of barriers including no data system that connects the two groups, internal data barriers, and challenges associated with the IHP program (e.g., the retrospective attribution of IHP patients, the inability to do panel work on the data the state provides to IHPs given the lag in these data).

Evaluation results suggest that the impact of Minnesota’s strict data privacy requirements (Minnesota Health Records Act) is ubiquitous, in many cases slowing progress and the advancement of the Minnesota Model. Providers face unique challenges when trying to share behavioral-health related information.

Providers encountered difficulties related to the market-based HIE structure in the state, particularly with regard to identifying and selecting an HIE service provider.

A concern for providers and organizations is the relatively short time window of the SIM initiative. The time frame for many grants is not conducive to measuring and meeting long-term goals such as clinical and population health improvement and reduction in costs.

While several Minnesota Accountable Health Model stakeholders have a seat on the two Task Forces, discussions with state leadership and select organizations participating in SIM e-Health activities suggest that some stakeholder groups are not actively engaged in the SIM initiative. These include a subset of payer representatives, some provider groups (e.g., medical, specialty, and nurse associations), consumers, many major employers, and some divisions and units within DHS and MDH.

Continuous Improvement Feedback
Several points of feedback surfaced during the evaluation’s discussions with participants from across Model investments:

- Grantees have valued the state’s flexibility in terms of program design and implementation and the ability to regularly communicate with the state.
- To facilitate information sharing and prevent duplicative efforts across grantees, there are opportunities for synergy across grant programs and Model drivers yet efforts to bring grantees together required time and resources for all involved. Ongoing monitoring and updating of
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**Insights for Sustaining the Minnesota Accountable Health Model**

In November 2015, DHS and MDH leadership consulted the Community Advisory and Multi-Payer Alignment Task Forces advising the state on the SIM award to confirm the continued relevancy of the four aims originally established for the Minnesota Accountable Health Model. During this meeting, state leadership and both Task Forces agreed that the aims remain appropriate and important and agreed with three priority areas drafted by the state for sustaining the Model. These include: continued efforts with health information exchange and data analytics; value-based purchasing and the alignment of incentives with desired outcomes; and community connections, partnerships, and authentic engagement.

Grantee experiences and insights reinforce these sustainability priority areas as well as recommendations recently made by the Minnesota Health Care Financing Task Force on state health care policy strategies.

- Grantees faced several challenges in addressing the state’s first priority sustainability area, including the state’s HIE structure, identifying a capable HIE service provider, state data privacy laws, and the financial sustainability of EHR and HIE costs. Without additional legislative changes to the Minnesota Health Records Act and response to other HIE challenges, workarounds developed as an alternative may be too costly and time consuming for smaller organizations to implement, thus limiting further advancement of the Minnesota Accountable Health Model.

- Regarding value-based purchasing and the alignment of incentives, IHPs discussed problems associated with a retrospective attribution model and their ability to manage patient care in the short term, their concerns about diminishing potential for savings given how cost benchmarks under the current payment methodology are adjusted over time, their difficulty in determining exactly what is working and what is not working, and their desire for prospective compensation for care management and other infrastructure. The Health Care Financing Task Force recommends the study of a number of changes and improvements called out by IHP grantees related to the attribution methodology, payment and measurement determinations, and timing of compensation.
The importance of community engagement and partnership development in facilitating practice transformation and care quality improvement was recognized by many SIM participants, calling attention to the crucial role of a central point person for making connections in the community, coordinating between health care providers and community-based resources, and overseeing the administration of transformation activities and communication. In some cases, this person is the administrative project manager for the grant; in other cases, this person may be a member of the care coordination team and is directly involved in the coordination of services for specific individuals; and in other cases, this person may play both roles. A number of grantees noted the significance of the grant funds in supporting community engagement and partnership development. Therefore, a key consideration in the sustainability of SIM efforts pertains to the funding options available for positions to carry out these functions.

One focus articulated by SIM grantees and the Health Care Financing Task Force but not explicitly identified in the current SIM sustainability priorities pertains to the payment for care coordination. Grantees expressed concerns about the sustainability of SIM-funded care coordination positions and efforts beyond the grant period given limited reimbursement options and levels for health care coordination. Several IHPs also argued for prospective payments to maintain their care coordination improvements and data analysis functions linked to redesigning care delivery.

Conclusion
The state of Minnesota has embarked on an ambitious effort to expand value-based arrangements and patient-centered, community-based service delivery and coordinated care through the implementation of the Minnesota Accountable Health Model. One key goal of Minnesota’s efforts is to develop new relationships across the medical care delivery system and local providers of health and social services to better meet the holistic needs of patients and communities and improve population health. The state’s SIM award has provided needed funds and infrastructure required for change but continued efforts will be required to sustain innovations over time.