EVALUATION OF THE MINNESOTA ACCOUNTABLE HEALTH MODEL

EXECUTIVE SUMMARY

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

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This report was written by the following staff at the State Health Access Data Assistance Center (SHADAC): Donna Spencer, PhD; Christina Worrall, MPP; Emily Zylla, MPH; Carrie Au-Yeung, MPH; Kelli Johnson, PhD; Lacey Hartman, MPP; Kristin Dybdal, MPA; Chad Parslow, MPP; Lynn Blewett, PhD; Amanda Napoles, MPH; Joseph Morris, MPH; Aaron Swaney, MPH; and Christina Carberry, MPH/MPP. Peter Huckfeldt, PhD, Heidi O’Connor, and Jiani Yu also contributed to the report – specifically, in the analysis and reporting of data from the Minnesota All Payer Claims Database (MN APCD) and the Minnesota Statewide Quality Reporting and Measurement System (SQRMS). SHADAC, housed at the University of Minnesota, School of Public Health, was under contract with the Minnesota Department of Human Services (DHS) to conduct the state evaluation of Minnesota’s State Innovation Model (SIM) initiative, the Minnesota Accountable Health Model (the Model). This document summarizes our final evaluation report, one of two reports containing results of SHADAC’s evaluation.

SHADAC would like to acknowledge the many contributions made to the evaluation by staff at DHS and the Minnesota Department of Health (MDH), the state agencies charged with implementation of the Model. Special thanks go to Krista O’Connor, Inter-Agency Project Lead; Monica Hammer, Staff Lead for Evaluation; and members of the Leadership Team for their thoughtful comments on report drafts. We also would like to thank the over 350 individuals from across the state who shared their time and insights related to their participation in Model programs and activities. Finally, the authors would like to acknowledge Lindsey Lanigan, Pearl Nielsen, and Ann Bobst, of SHADAC, for their assistance with report layout, preparation, editing, and exhibit production.

This evaluation is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Department of Human Services in 2013 by The Center for Medicare and Medicaid Innovation. Administered by the Minnesota Departments of Health and Human Services, the funding was used to implement the Minnesota Accountable Health Model framework. The results of this evaluation are not endorsed by the federal government. These findings do not reflect the views of and may differ from the federal government’s evaluation.
EXECUTIVE SUMMARY

This document summarizes the final results of the state evaluation of Minnesota’s State Innovation Model (SIM) initiative. SIM, sponsored by the Centers for Medicare and Medicaid Services (CMS) and administered by CMS’s Center for Medicare and Medicaid Innovation (CMMI), provided funding and support to 38 states/territories 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. Minnesota was one of the first states to be awarded a SIM cooperative agreement, and between January 2013 and September 2017, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) implemented and tested the Minnesota Accountable Health Model (the Model). Between 2015 and 2017, the University of Minnesota’s State Health Access Data Assistance Center (SHADAC) conducted the evaluation of SIM in Minnesota under a contract with DHS and in collaboration with both DHS and MDH. This evaluation report draws on SHADAC’s First Annual Evaluation Report delivered in 2016 and provides final results for the last two years of Minnesota’s initiative. Key accomplishments and outcomes across the Model are below.

- The state expanded and advanced its Medicaid Accountable Care Organization (ACO) program—called Integrated Health Partnerships, or IHPs—and was viewed by IHP provider systems as a leader among payers in data analytics and reporting.
- The number of SIM-collaborating organizations participating in alternative payment models (APMs) increased over the period of the cooperative agreement, although this increase occurred primarily in the Medicaid market.
- SIM e-health investments increased provider connections to the state’s Health Information Exchange (HIE) infrastructure and expanded statewide HIE vendor capacity.
- State practice transformation programs and activities under SIM situated emerging professions practitioners in select front-line work settings, led to improvements in the capacity of participating providers and organizations to deliver coordinated care across settings, supported new and existing Health Care Homes (HCHs), and facilitated the successful launch of Behavioral Health Homes (BHHs).
- Accountable Communities for Health (ACH) community-based care coordination led to improvements in care quality and patient outcomes, and individual ACH evaluations provided some evidence of cost savings.
- The state developed knowledge of the ACO market, engaged stakeholders, and built relationships that may help to support future discussions about ACO multi-payer alignment.
- Through joint-agency leadership, intentional stakeholder engagement, and the distribution of grants across the state with the flexibility to support innovative local reform models, DHS and MDH fostered new and strengthened relationships across sectors within the state, and broadened the conversation about health to one that goes beyond the medical care system to consider community characteristics and social determinants of health.

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1 The state’s initial time frame for conducting this work was between October 2013 and December 2016; a no-cost extension granted by CMMI extended Minnesota’s initiative through December 2017.

Minnesota Accountable Health Model

In Minnesota, the SIM cooperative agreement was used to advance the Minnesota Accountable Health Model (the Model). The Model was built 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 Minnesota e-Health Initiative, Community Care Teams (CCTs), and standardized quality measurement and reporting across payers. The aims of the Model were to transform the state’s health care system to achieve the following by the end of the SIM initiative.

- The majority of patients receive care that is patient-centered and coordinated across settings;
- The majority of providers are participating in ACO 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; and
- Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals.

The state, defined as DHS and MDH leadership and staff, organized SIM programs and activities under five primary drivers or strategies and executed this work primarily through competitive grants and contracts to organizations and providers across the state as well as through stakeholder engagement efforts. The five drivers include:

- **Driver 1**: Advance providers’ ability to exchange clinical data for treatment, care coordination, and quality improvement;
- **Driver 2**: Increase providers’ access to analytic tools to manage cost/risk and improve care quality;
- **Driver 3**: Expand the number of patients served by team-based integrated/coordinated care;
- **Driver 4**: Increase provider/community/consumer partnerships to identify health and costs goals and take on accountability for population health; and
- **Driver 5**: Standardize ACO performance measurement, competencies, and payment methodologies, particularly for complex patients.

Minnesota’s investments across these drivers can be organized into three main components. First was a joint-agency governance and management structure including both DHS and MDH that facilitated cross-agency collaboration to operationalize and implement the Minnesota Accountable Health Model. Second was the engagement of a broad group of stakeholders leveraged to guide the initiative, achieve community engagement and partnership goals, and disseminate information about the initiative. Stakeholders included “SIM priority setting” providers, specifically behavioral health providers, social service agencies, local public health agencies, and long-term care/post-acute services providers. The third area of investment was the administration and oversight of competitive grants and contracts to organizations and collaboratives across the state to achieve the goals of each of the five drivers (totaling over 150 awards and more than $26 million). The state made direct investments to organizations and collaboratives as well as “support” investments to vendors/consultants and state agencies charged with facilitating the transformation of provider practices, organizations, and collaboratives to deliver accountable care.
Evaluation of the SIM Initiative
The Center for Medicare and Medicaid Innovation (CMMI) required two levels of evaluation of the SIM initiative: 1) a federal multi-state evaluation, which is being conducted by a federal contractor, RTI International; and 2) individual state evaluations. Evaluations directed by individual states were initially intended by CMMI to be formative evaluations for each respective state and it’s in state stakeholders, allowing for internal review and continuous improvement. State evaluations varied in their focus and scope. In Minnesota, DHS executed a contract with SHADAC in July 2014 to design and conduct a broad, initiative-level evaluation that emphasized the documentation, monitoring, and assessment of most core activities.

In collaboration with DHS and MDH, SHADAC identified several goals for the state’s evaluation, and these goals were applied to each of the five Model drivers. Evaluation goals included: document activities under the Model; document the variation in design, approach, and innovation of those activities; examine how the driver programs have contributed to advancing the state’s goals for the Model; and identify lessons learned for program sustainability. The evaluation drew upon both quantitative and qualitative data. Key data sources include a comprehensive database of organizations participating in SIM; semi-structured qualitative interviews with state leadership and staff as well as grantees, contractors and collaborators engaged in the SIM initiative; three surveys designed specifically for the state evaluation—SIM Minnesota Organization Survey, Accountable Communities for Health (ACH) Provider Survey, and Health Information Exchange (HIE) User Survey; the Minnesota All Payer Claims Database (MN APCD); the Minnesota Statewide Quality Reporting and Measurement System (SQRMS); and state, grant, and contract documents.

This Executive Summary is based on the final state evaluation report, which includes driver-specific results as well as findings that cross Model drivers. Both documents describe the key activities conducted under the Model, summarize the SIM investments made by Minnesota, present outcomes of select SIM initiatives and cross-driver Model outcomes, and discuss the sustainability of Model investments beyond the SIM funding.

Model Investments/Governance, Activities, and Innovative Approaches
Throughout the implementation of SIM Model activities, the state was committed to its joint-agency leadership, its stakeholder engagement processes, and its original conceptual approach, outlined in a Driver Diagram. Staff from both DHS and MDH were members of the SIM governance structure, which included an Executive Committee, Leadership Team, and Core Workgroups. The SIM Leadership Team remained the most active body, meeting weekly to oversee, manage, and monitor initiative programs and activities. The state sought input from key stakeholders, namely members of the two SIM Task Forces—the Community Advisory Task Force and the Multi-Payer Alignment Task Force—regularly over the four-year award. Task force subgroups volunteered their time to dive deeper into Model design, including the development of the Minnesota Accountable Health Model Continuum of Accountability.

3 Another evaluation goal was to identify opportunities for continuous improvement. Please refer to SHADAC’s First Annual Evaluation Report for findings related to continuous improvement as well as more information about barriers to and facilitators of Model implementation.

4 See Exhibit 2.1 in the First Annual Evaluation Report for a depiction of Minnesota’s SIM governance structure.

Assessment Tool and the Accountable Communities for Health (ACH) Grant Program.
Task force subgroups also tackled challenging topics, such as prioritizing and aligning data analytics across providers and payers. A DHS SIM inter-agency project lead played a significant management role in monitoring the multi-million dollar cooperative agreement with the federal government, facilitating the dual agency governance structure, administering and overseeing almost one hundred grants and contracts, and engaging external task forces.

The state organized Model activities according to the primary drivers they support, recognizing that driver-specific work was overlapping and complementary (each driver is described in detail below). The state also recognized that Model implementation not only facilitated the implementation of new programs, such as ACHs and the BHH program, but also accelerated the rollout of reforms that predated SIM, such as the IHP program (Minnesota’s Medicaid ACO model). At a high level, Minnesota used SIM funding to support the following efforts.

- Engagement of stakeholders/resources within communities and across sectors;
- Clinic-based and community-based care coordination;
- Exchange of health information to improve care coordination and quality;
- Use of data for decision making by providers;
- Population health initiatives; and
- Provider preparation for participation in delivery system and payment reforms.

Exhibit ES.1 below summarizes specific key activities completed under the Minnesota Accountable Health Model, organized by Model drivers. The exhibit includes the approximate dollars invested in each driver, SHADAC’s estimates of the number of organizations participating in activities under each driver (as either recipients of SIM funding or collaborators on SIM-funded work), and examples of innovative approaches employed by the state or by SIM participating organizations. The state also invested in cross-driver activities, such as strategies to promote authentic community engagement, equity and communications, and these activities are described in the last row of Exhibit ES.1.

Exhibit ES.1. Minnesota Accountable Health Model Programs, Activities, and Innovations by Driver

<table>
<thead>
<tr>
<th>Driver and Goal ($ invested)</th>
<th>SIM Programs and Organizations* Involved</th>
<th>Key Activities</th>
<th>Examples of Delivery System or Payment Reform Innovations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver 1. Health Information Technology (HIT)/Health Information Exchange (HIE) Goal: Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement ($7,026,578)</td>
<td>E-Health Collaborative Grants: 158 organizations E-Health Roadmap: 51 organizations Privacy, Security, and Consent Grant: 1 organization</td>
<td>- Established partnerships between medical and priority setting providers (behavioral health, long-term and post-acute care, local public health, and social services), which prepared for and implemented HIE method - Provided recommendations and actions to providers to support/accelerate e-health in priority settings</td>
<td>E-Health Collaborative Grants - Engaged provider partners, including behavioral health and social services, in HIE discussions - Defined use cases that facilitate exchange of non-standard data among multiple care settings - Afforded the opportunity for many collaboratives to revise work when full implementation of Direct Secure Messaging (DSM) alone did</td>
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<tr>
<th>Driver and Goal ($ invested)</th>
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</table>
| Driver 2. IHP Data Analytics Goal: Providers have analytic tools to manage cost/risk and improve quality ($6,063,472) | HIE and Data Analytics Grants: 57 organizations** | • Provided education and technical assistance (TA) to health care professionals on privacy, security, and consent management practices  
• Expanded work of e-Health Collaboratives and IHPs in HIE methods and/or data analytics | not achieve many of the desired use cases; In a third round of SIM HIE funding, collaboratives focused on Admit-Discharge-Transfer (ADT) alerts and establishment of data warehouses that would allow for data analytics |
|                               | IHP Data Analytics Grants and Vendor Contract: 12 organizations (7,909 participating providers) | • Enhanced state’s data reporting to IHPs  
• Advanced IHP providers’ use of data for decision making  
• Assisted the state in IHP program data analytics and documentation  
• Supported the participation of a community partner in the IHP program | IHP Data Analytics Grants  
• Developed indicators related to social determinants of health  
• Implemented evidence-based changes to work flow to support care coordination needs |
|                               | Food Security Grant: 7 organizations** | | Food Security Grant  
• Developed food security services screening and referral system and disease-based interventions in two health care delivery systems for Minnesota Health Care Program beneficiaries |
| Driver 3. Practice Transformation Goal: Expanded numbers of patients served by team-based, integrated/coordinated care ($3,058,436) | Emerging Professions Grants and Toolkits: 67 organizations | • Hired staff in emerging professions and integrate them into existing care teams  
• Developed tools and resources to aid employers in the integration of emerging professions  
• Integrated primary care and priority setting providers as well as dental services  
• Provided coaching and TA to providers in building capacity in patient-centered care teams  
• Compiled learning teams of providers to share practice transformation experiences | Emerging Professions Program  
• Built on Minnesota’s leading role in adopting and promoting community health workers, dental therapists and community paramedics as members of the provider community  
Practice Transformation and Facilitation Programs  
• Enabled providers to prepare to successfully seek BHH certification  
Oral Health Access Project  
• Co-located dental services within system-affiliated health care home to address access barriers; included emerging professions and county social services on care team and related information sharing |
|                               | Practice Transformation Grants: 61 organizations | | |
|                               | Oral Health Access Award: 1 organization** | | |
|                               | Practice Facilitation: 27 organizations | | |
|                               | Learning Communities (all rounds) and Days: 35 organizations** | | |
| Driver 4. Accountable Communities for Health Goal: Provider organizations partner with communities and engage consumers to identify health and cost goals and take on accountability for | ACH Grant Program, including TA provider: 237 organizations | • Formed community collaboratives to design and implement community-based care coordination approach and population health plan for target population in community  
• Provided TA to community collaboratives in the areas of | *Supported the development and evolution of ACHs in Minnesota  
• Brought a broad set of stakeholders to the required leadership and care coordination teams (e.g., law enforcement, schools, hospitals, health plans, individual community members, youth programs) and did so in unique ways (e.g., using }
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</thead>
<tbody>
<tr>
<td>population health ($6,189,249)</td>
<td>community engagement, care coordination, data analytics, etc.</td>
<td>community consultants, &quot;dyadic&quot; leadership structure</td>
<td>- Provided community-based care coordination and population health services and resources to address both health and social determinants of health, often through innovative mechanisms (e.g., drumming circles, mindfulness training, art classes, adverse childhood experiences [ACEs] education) and anchoring services in non-traditional (i.e., non-medical) settings to more effectively engage target populations</td>
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**Driver 5. Accountable Care Organization (ACO) Alignment**

**Goal:** ACO performance measurement, competencies, payment methodologies are standardized, and focus on complex populations ($ not available)

- **IHPs:**
  - 21 organizations (9,299 participating providers)
  - 2015 ACO Baseline Assessment
  - Respondents: 65 providers and 8 plans**

- **Increased the number and type of provider systems participating in the IHP program**
- **Increased DHS infrastructure to support expanded IHP program**
- **Assessed the extent to which accountable care organization (ACO) arrangements exist within the state**
- **Assessed self-insured and Minnesota All Payer Claims Database participation**

**IHP Program Expansion**

- **Expanded and enhanced IHP program (alternative payment arrangements between the state Medicaid and provider organizations based on TCOC and risk or gain sharing as well as on quality and patient experience)**

**ACO Alignment**

- **Designed and administered a survey to assess ACO penetration in Minnesota**

**Select Cross-Driver Activities ($ not available)**

- **Community engagement and partnership**
  - Two task forces: 33 organizations**
  - Storytelling and Narrative** projects:
    - 6 organizations (158 individuals attended Equity Summit)
  - Regional Meetings: 5 host organizations

- **Communications**
  - 6,000 SIM Home Page views in 2016 and 800 recipients of SIM monthly bulletin

- **Advised state leadership on initiative**
- **Developed narratives about health, health care, barriers to care, community engagement and partnerships, care coordination, and health equity.**
- **Disseminated information about SIM initiative through website, monthly bulletin, success stories, fact sheets**

- **Expanded who is “at the table” (e.g., different state agencies, both larger and smaller medical providers, both medical and priority setting providers)**
- **Developed storytelling products aimed at illustrating the interaction of various communities and the health care system and ways to reach communities about health**
- **Committed to joint-agency leadership, management, and communications**

*Organizations involved include fiscal agents, collaborating partners, and vendors.

**These programs were not a focus of the state led evaluation. Due to limited data at the writing of this report, counts and award amounts associated with recent SIM investments, namely the IHP Alerting Service, e-Learning Module, and Community Engagement Narrative project, are not included in this table.
**Broad Reach of SIM Investments to Various Provider Types across Minnesota**

A key role of the state under SIM was to award, distribute, and oversee grants to organizations and communities across Minnesota and support a flexible reform approach, such that communities were empowered to design unique reform models tailored to local needs and capacities. Under this approach, which supported the state’s ongoing commitment to stakeholder and community engagement, a wide variety of organizations participated in the Minnesota Accountable Health Model as recipients of SIM funding (fiscal agents) or collaborators in SIM-funded efforts. The state “spread” its investments statewide, and it also “stacked” its investments, such that it intentionally supported some organizations to participate as fiscal agents in more than one unique SIM program. The following summarizes the makeup of the 495 organizations that participated in SIM between 2014 and 2017:

- Ninety-eight (98) fiscal agents received over 150 awards from the state, each usually serving as the lead organization on a particular grant or contract.
- Almost 400 organizations (397) collaborated with fiscal agents on one or more SIM grant or contract, for a total of 495 organizations participating in SIM.
- Over 40% of organizations were located in rural counties across the state.
- A total of 150 organizations were involved in two or more SIM programs (up from 104 in the first year of the initiative).
- Twenty-seven percent (27%) of participating organizations were medical providers; 41% were priority setting providers (behavioral health (12%), social services (15%), local public health (5%), long-term/post-acute supports and services (5%)); and 32% were other types of organizations (including payers, educational institutions, associations, food service organizations, pharmacies, emergency medical services organizations, and other community organizations).

Exhibit ES.2 shows the geographic distribution and award amounts of grant and contract fiscal agents under SIM in Minnesota.
Exhibit ES.2. Map of Minnesota Accountable Health Model Fiscal Agent Awards


Notes: Database is based on state documentation, grant applications and agreements, select progress reports and grantee interviews, organization websites, and consultation with the state. Two fiscal agents are not plotted on the map due to their out of state location. Due to limited data at the writing of this report, recent SIM investments, namely the IHP Alerting Service, e-Learning Module, and Community Engagement Narrative project, are not included.

Key Model Outcomes
SHADAC’s initiative-level evaluation design allowed for data collection across a variety of SIM programs and activities and supported reporting of evaluation findings both by Model driver and across drivers and at the state and organization levels. In this section, we identify select accomplishments and outcomes under each of Minnesota’s five drivers, followed by a summary of cross-driver outcomes. The results presented below and in the full report exclude outcomes of SIM investments that were implemented during the state’s no-cost extension (NCE).  

Select Accomplishments and Outcomes of Model Program and Activities
Exhibit ES.3 identifies select accomplishments and outcomes under each of Minnesota’s five drivers based on both qualitative and quantitative evaluation data sources.

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7 Due to limited data at the writing of this report, recent SIM investment were not evaluated. For example, SHADAC was not able to incorporate programs implemented under the state’s no-cost extension (see activities noted in Exhibit ES.1). Additionally, the outcomes presented in this report are based on final interviews conducted in the spring/summer of 2017 and document review through September 15, 2017. Therefore, because some grants and contracts do not come to a close until December of 2017, some program outcomes may not be captured here.
### Exhibit ES.3. Select Accomplishments and Outcomes of Model Program and Activities included in the Evaluation

<table>
<thead>
<tr>
<th>Goals, Accomplishments, and Outcomes by Driver</th>
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<tr>
<td>Driver 1. Health Information Technology (HIT)/Health Information Exchange (HIE) Goal: Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement</td>
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**e-Health Collaborative Grants**
- Seven of the nine implementation collaboratives (78%) connected to a state-certified HIE service provider. Of those, four reported successfully exchanging new health information among partners as a result of SIM funding, and three achieved the testing phase of exchange.
- Full implementation of Direct Secure Messaging (DSM) alone did not achieve many of the collaboratives’ desired use cases. Several collaboratives revised their work to focus on exchanging Admit-Discharge-Transfer (ADT) alerts and to establish data warehouses that would allow for data analytics.
- Seventy-four percent (74%) of e-health implementers who responded to the SIM Minnesota Organization Survey perceived that, over the course of the SIM, their organizations made advancements in the availability, use, and exchange of e-health information. In fact, 62% of e-health implementer respondents reported exchanging information with at least one more organization or stakeholder type now than before SIM.
- The majority of e-health implementers reported in interviews increased knowledge of e-health technology and capabilities and increased awareness of privacy and security issues.
- Evaluation data are limited on workflow efficiencies and cost savings that result from HIE methods.
- Collaborative participants who responded to the Organizational Survey endorsed several key benefits to working in collaboratives including acquiring new useful knowledge about services programs or people (51%), developing valuable relationships (51%), and developing new skills (32%).
- The SIM e-Health Collaborative “test” advanced implementation of the state’s strategy to achieve statewide interoperability, placing greater emphasis on providers connecting directly with HIOs. HIO infrastructure was strengthened in the state and was supported by SIM investments.

**e-Health Roadmap**
- SIM participants developed compelling use cases into a single roadmap applicable across medical, behavioral health, social services, public health, and long-term/post-acute services and support settings.
- Stakeholders from across the care continuum were effectively engaged in various capacities.

**Privacy, Security, and Consent Grant**
- A Foundations in Privacy Toolkit, designed to address challenges providers face exchanging health information under Minnesota and federal laws, was published online.

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<th>Driver 2. IHP Data Analytics Goal: Providers have analytic tools to manage cost/risk and improve quality</th>
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<tbody>
<tr>
<td><strong>IHP Data Analytics Grants</strong></td>
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- DHS continued and enhanced its provision of consistent data and technical assistance (TA) to IHPs; IHPs consider DHS a leader in data analytics in the state.
- Data analytics facilitated IHP learning and planning for populations they serve.
- The majority of IHPs used SIM funds to integrate state IHP data into a new or existing data warehouse for enhanced analytics and/or to conduct enhanced analytics for care coordination.
- Qualitative evaluation data suggest efficiencies were gained among many IHPs through automation and newly accessible information has been leveraged to expand care coordination activities. Interview findings also suggest that learning and skills acquired under this grant are applicable to other delivery system and payment reform efforts or other patient populations.
Goals, Accomplishments, and Outcomes by Driver

Driver 3. Practice Transformation Goal: Expanded numbers of patients served by team-based, integrated/coordinated care

**Emerging Professions, Practice Transformation (Round 1-3), and Practice Facilitation Grants**

- Overall, the number of certified HCHs in the state modestly increased. In the first quarter of 2015, a total of 351 clinics were certified HCHs. In June of 2017, that number had increased to 376 clinics (including 20 clinics in border states). As of August 2017, there were 26 certified BHHs. Sixty-nine percent (69%) of BHHs were recipients of SIM grants.

- Almost 7,000 people were reportedly served by SIM awardees testing the use of emerging professions in their provider organizations.

- A collaborating team from the Institute for Clinical Systems Improvement (ICSI) and Stratis Health as well as the National Council for Behavioral Health assisted SIM awardee organizations in the establishment of process goals, and almost all of the 23 participants achieved their desired goals (e.g., reduced ED visits, increased referral form completion, implemented new assessment for diabetes patients, became BHH-certified, built or used patient registries, accelerated or improved behavioral health and primary care integration).

- Among the 38 organizations participating in Driver 3 that responded to the Organization Survey, 85% (weighted) reported their organization’s care coordination abilities at the time of the survey were better than prior to SIM.

- Qualitative data suggests enhanced care coordination among grantee organizations in terms of improved communication among providers, revised staffing to allow providers to work at top of license, more patient referrals to other services, more concerns addressed in a visit, and improved transitions of care.

Driver 4. Accountable Communities for Health Goal: Provider organizations partner with communities and engage consumers to identify health and cost goals and take on accountability for population health

**ACH Grants**

- Seventy-eight percent (78%) of ACH participating organizations responding to the Organization Survey reported increases in relationship formality with at least one stakeholder type, especially priority setting provider organizations. Fifty-six (56) Organization Survey respondents identified the following benefits of working in ACHs: the development of valuable relationships; gaining new useful knowledge about services, programs, or people; and the development of new skills. These findings were reiterated by the 183 respondents to the ACH Provider Survey when asked specifically about ACH care/service coordination.

- Seventy-eight percent (78%) of ACH Provider Survey respondents stated that care/service quality was somewhat or much improved as a result of ACH care coordination services. Quality indicators mentioned most often by ACHs interviewees included: care becoming more patient-centered, improved patient/client experiences and satisfaction, and improved management of care transitions and chronic conditions.

- At least eight ACHs interviewed noted that provider satisfaction increased as a result of ACH care coordination efforts, and 84% of ACH Provider Survey respondents indicated that they would like to continue to participate in or use the ACH care coordination services.

- Seventy-three percent (73%) of ACH Provider Survey respondents indicated that ACH care coordination services had a positive impact on provider workload, and a similar percentage (74%) reported that ACH care/service coordination had a positive impact on provider workflow.

- A subset of ACHs collected data on service utilization and health care costs. Five of the six ACHs that assessed ED visits saw decreases in ED utilization, and three of the four ACHs that monitored inpatient hospitalizations saw decreases in inpatient stays over time. There was limited tracking of costs and limited evidence of ACH impact on health care costs, although two ACHs did show a reduction in health care costs among their care coordinated populations. One of the two ACHs found a 55% reduction in total ED costs between 2015 and 2016 among patients enrolled in ACH care coordination, for a savings of $29,304. The other ACH examined total pharmacy claims among the ACH target population before and after the ACH intervention and found a 9% drop in claims between the last four months of 2014 and the same time period in 2015, representing a $439,674 cost reduction.
Goals, Accomplishments, and Outcomes by Driver

Driver 5. Accountable Care Organization (ACO) Alignment Goal: ACO performance measurement, competencies, payment methodologies are standardized, and focus on complex populations

IHP Program

- Since 2013, IHPs expanded in number from six to 21 organizations in 2017, from 97,000 to 461,000 MHCP beneficiaries in 2017 (exceeding 2016 and 2017 goals), and from 2,800 to 9,300 in individual providers in 2016.
- DHS estimated state cost savings and shared savings for IHPs for the first four years of the program. According to preliminary state actuarial analysis, IHPs have achieved a total cost savings of $212.8 million between 2013 and 2016. Roughly $70.5 million of the total cost savings reported has been or was expected to be returned in the form of shared savings settlements to IHPs who met cost and quality targets.
- SHADAC analysis of trends using MN APCD and SQRMS data show reductions in emergency department (ED) and hospital utilization for both children and adult Minnesota Health Care Program (MHCP) enrollees for Round 1 IHPs during the first two years of program participation (2013-2014) relative to 2012. We also observed for Round 1 IHPs overall reductions in inpatient costs for both children and adults enrolled in MHCP. Most of these changes were also visible for Round 1 IHP commercial enrollees, but only adult MHCP enrollees had an overall reduction in total costs. We found some evidence that MHCP and commercial health care costs increased for Round 2 IHPs during their first year in the IHP program (2014). On average, we find no significant change in Round 1 IHP quality performance for both MHCP and commercial patient populations during the study period.
- Expansion and diversity of participating IHP providers informed enhancement in model design (referred to as IHP 2.0), which included prospective care coordination payments, the exchange of electronic clinical event notifications between IHPs and providers, and incentives that strengthen partnerships between IHPs and community support/social service organizations.

ACO Status and Alignment

- The 2015 ACO Baseline Assessment found that ACO participation in the state’s commercial market was relatively high, with 41% of fully insured covered lives attributed to ACO models. The percentage of revenue at risk in ACO or similar arrangements was low, with two-thirds of provider respondents indicating that 10% or less of their organization’s revenue was at risk.
- The 2017 SIM Organization Survey found that 31% of organizations participating in SIM programs and activities reported an increase in their level of implementation of alternative payment models (defined as percent of organization revenue “at risk”) before and after being involved in SIM. These survey data show that the increase among SIM participants was primarily in Medicaid.
- Conditions did not exist in the market such that significant, tangible progress could be made under SIM in developing aligned quality measures, core competencies, or payment methodologies for ACO arrangements in the state.
- Stakeholders identified several barriers in this work including the small base of public programs, the competitive nature of health plans, a lack of tangible goals for alignment under SIM, and lack of ACO regulation under state statue.
- Nonetheless, interviewees identified several areas of progress under SIM including increasing knowledge of the ACO market, engaging stakeholders around the topic, and building relationships that may help facilitate productive discussions about ACO alignment in the future.
- This progress informed the ongoing development of the IHP program, where the state has leverage as a purchaser of health care services.

Summary of Key Cross-Driver Outcomes

Looking across driver findings, we identified eight key cross-driver outcomes from the Minnesota Accountable Health Model initiative:

- Expanded capacity among providers to deliver coordinated care across settings;
- New pockets of electronic health information exchange (HIE) and increased demand for data analytics;
- Expanded provider participation in alternative payment model (APM) arrangements under Medicaid;
- Some evidence of reductions in health care utilization and costs among Round 1 IHPs;
- Some evidence of Triple Aim achievements among ACHs;
- Little momentum in multi-payer ACO alignment;
- New or strengthened relationships across providers, organizations, and the state; and
- Broadened conversation about health within the state.

Expanded Capacity to Deliver Coordinated Care across Settings

The aims of the Minnesota Accountable Health Model included the delivery of coordinated care across providers and organizations and collaborative approaches to delivering high quality care in order to improve population health. SHADAC interviews with providers and organizations participating in SIM and weighted results from the SIM Minnesota Organization Survey provide evidence of expanded capacity to deliver coordinated care or services across medical providers, priority setting providers, and community organizations.

Interviewees from e-Health Collaborative and ACH Grant Program participants articulated that an artifact of the new and deepened organizational partnerships achieved through these collaboratives was increased knowledge related to organizational capacity and expertise and how various providers and organizations may fit together to address the health and social needs of community members and patients. Some ACH interviewees noted that this knowledge helped them to relate to patients/clients; assess an individual’s situation and strategically develop a plan of care; tap the right resources and link to them; and avoid duplicating efforts. This knowledge was crucial for progressing toward Minnesota’s aim of patient-centered, team-based, and coordinated care.

State Innovation Model (SIM) participants described many positive impacts related to enhanced care coordination capacity. They included improved screening for mental health and chronic conditions, improved staffing models and workflows, better discharge planning and post-hospitalization care, and increased referrals to non-medical providers. Grantees also reported increased access to and use of data to support population management and to help identify individuals in need of care coordination and assessment. IHPs, which receive data from the state about utilization by attributed patients outside individual provider systems, cited the importance of having statewide information about emergency department (ED) utilization and hospitalizations in order to appropriately target interventions.

Most SIM Minnesota Organization Survey respondents reported that the capacity of their organizations to provide care coordination had increased under SIM. Overall, 73% of respondents believed their organizations’ care coordination capabilities were somewhat or much better because of SIM. Nearly 50% of organizations or more reported progress over time in the following care coordination capabilities in
particular: use of designated care coordinated staff, identification of patients for care coordination, assessing patient social determinants, and inclusion of patient/family in decision making.

Results from the SIM Organization Survey also indicated greater access to data and some progress related to data-driven decision making. Forty-five percent (45%) of the responding organizations reported an increase in data access or collection over the course of their SIM participation. Progress was made across all data source types, including Medicaid claims data, administrative data, clinical data, and socio economic data. While the majority of respondents (83%) reported no change in how they use data during the SIM initiative, among survey respondents who did report a positive change (meaning their organizations progressed from no use to either planning or implementation of a specific way to use data), slightly more organizations made progress in the category of client/patient-focused tracking. One grantee explained the importance of data to build care coordination capacity. “Two key factors specific to IHP that were significant include expansion of data available to IHPs to advance that body of work and continued relationship development with area providers participating in the IHP network. The IHP care coordination work was actually very helpful in informing our implementation of the ACH diabetes prevention work, and understanding the best ways to utilize data to most efficiently target resources for a given population.” One IHP respondent reported that there is more work to do: “The ability to review data and share – that enabled us to develop systems and processes for better care coordination. We have learned that even with the data, it takes a long time to shift the culture of health systems away from fee for service to looking ahead at care opportunities.”

**New Pockets of Electronic HIE; Increased Demand for Data Analytics**

Minnesota has long been a leader in e-health, and consistently ranks as one of the states with the highest rates of hospital and ambulatory clinic EHR adoption in the country (100% and 97%, respectively). As it carried out its work related to Meaningful Use, the state recognized that there was a continued need to support the achievement of interoperability, both across traditional health care organizations and across a broader set of providers and settings that had not been recipients of meaningful use incentive payments such as social service providers, local public health, home health settings, etc. Interoperability goals have been more difficult to achieve than Meaningful Use goals, although progress has been made recently.

Minnesota’s Driver 1 investments under SIM built on the significant e-health work that had already occurred in state over the past decade. One of the key driver goals was to support the secure exchange of medical or health-related information between organizations through implementation and expansion of e-health capabilities under the e-Health Collaboratives Grant Program. Among the nine e-Health Collaboratives working toward HIE implementation, seven implemented the required HIE infrastructure by connecting to a state-certified HIE service provider. Five of those collaboratives connected through a Health Data Intermediary (HDI), with most pursuing Direct Secure Messaging (DSM). Two focused on the exchange of Admit-Discharge-Transfer (ADT) alerts, or other care summary transactions (e.g., Continuity of Care Documents or CCDs) through a Health Information Organization (HIO). However, only one collaborative reported that all of their partner organizations had successfully connected to the HIE and were exchanging information. At the time of SHADAC interviews, most collaboratives were either still in a testing phase or sending and receiving health information with a subset of partner organizations.

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Because the e-Health Collaborative grantees were still in the process of (or had yet to begin) on-boarding partners to their HIE at the time of interviews, many participants commented that it was too early to observe outcomes related to HIE implementation such as changes in care quality, workflow, and cost. However, grantees did report interim results, and an evaluation survey of current HIE users in four e-Health Collaboratives identified experiences with DSM. These interim outcomes included the following:

- Increased knowledge of e-health technology and capabilities;
- Increased awareness of privacy and security issues;
- Advancements in care coordination model development;
- Increased desire to and improved understanding of how to harness e-health tools for analytics;
- Increased timeliness of information (regarding DSM); and
- Strengthened relationships between collaborative partners.

Broader impacts of the state’s efforts to support secure HIE included increased statewide HIE vendor capacity (now up to 4 HIOs, for example) and further implementation of a strategy to achieve statewide interoperability that requires connecting directly with an HIO or indirectly to an HIO through an HDI.

**Expanded Provider Participation in Alternative Payment Model Arrangements under Medicaid**

One goal under Driver 5 of the Model was the expansion of the Medicaid IHP program, which aligns financial incentives to promote the Triple Aim – improve patient experience, improve population health, and reduce health care costs – and provider accountability. Following its inception in 2013, and during the SIM initiative, the number of health care delivery systems participating in the IHP program grew. As of June of 2017, the program expanded from six to 21 IHP organizations and from covering nearly 97,000 to over 461,000 Minnesota Health Care Program (MHCP) beneficiaries. The number of clinicians participating as rostered providers in IHPs also increased steadily, from approximately 2,800 in 2013 to 9,300 in 2016. Although the IHP program existed prior to the SIM initiative, its expansion is partially due to SIM investments. SIM funding allowed DHS to hire additional data analytics, quality, and contracts staff and actuarial resources that were instrumental to working with new and increasingly diverse organizations that were interested in participating in the program.

In 2015, the state conducted an ACO Baseline Assessment to gauge the extent to which ACO models exist within the state beyond the Medicaid market. This study found that approximately 50% of clinics, hospitals, and physicians participate in an ACO either directly or via their organization and that approximately 40% of fully-insured lives were attributed to ACO models. Another significant finding was the relatively low percentage of revenue many providers had at risk in ACO arrangements in the broader health care market (two-thirds of assessment respondents reported 10% or less of revenue). The collection of assessment data has not been repeated, so it is not possible to examine changes in ACO participation over time. However, the expansion of provider participation in APMs under Medicaid was further reinforced by results of the SIM Minnesota Organization Survey, which found that the

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percentage of SIM organizations participating in a Medicaid APM was higher following SIM participation (see Exhibit ES.4).

**Exhibit ES.4. SIM Organizations Participating in APMs Before and After SIM, by Payer**

<table>
<thead>
<tr>
<th>Payer</th>
<th>Before SIM</th>
<th>Medicare</th>
<th>Commercial Fully-Insured</th>
<th>Commercial Self-Insured</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before SIM</td>
<td>48%</td>
<td>27%</td>
<td>26%</td>
<td>19%</td>
<td>10%</td>
<td>31%</td>
</tr>
<tr>
<td>After SIM</td>
<td>65%</td>
<td>32%</td>
<td>28%</td>
<td>19%</td>
<td>7%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Notes: Organizations could choose multiple payers. Organizations responding to the “before SIM” question totaled 78. Organizations responding to the “after SIM” question, which refers to the time of survey administration, totaled 80. Percentages are based on analysis of weighted results.

**Some Evidence of Reductions in Health Care Utilization and Costs among Round 1 IHPs**

As part of the state evaluation, SHADAC conducted analyses of the Minnesota All Payer Claims Database (MN APCD) and the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) to examine health care outcomes for MHCP enrollees and for commercial patients of providers and clinics participating in Minnesota’s IHP program. The purpose of these analyses was to examine whether and how health care utilization, costs, and quality have changed under MHCP during early IHP participation and whether similar or different trends are visible for IHPs’ commercial patients. We used MN APCD data for 2012-2014 and SQRMS data for 2011-2014 to examine trends in outcomes for Round 1 IHPs (which took effect in 2013) and Round 2 IHPs (which started in 2014).

Our analyses show reductions in ED and hospital utilization for both children and adult MHCP enrollees for Round 1 IHPs during the first two years of IHP program participation. The overall reduction in ED use relative to 2012 was approximately 3.0 percentage points for both children and adults, and hospitalizations were reduced by 0.7 and 1.7 percentage points for MHCP children and adults, respectively. We also observe for Round 1 IHPs reductions in inpatient costs for both children and adults enrolled in MHCP during the same time frame (-$2 for non-acute inpatient for children and -$202 for acute inpatient for adults). We observe similar trends among Round 1 IHP commercial health plan enrollees, although it is only for adult MHCP enrollees that we see an overall reduction in total costs (-$176). We find some evidence that MHCP and commercial health care costs increased for Round 2 IHPs during their first year in the IHP program. On average, we find no significant change in Round 1 IHP quality performance for both MHCP and commercial patient populations during the study period.

The Minnesota Department of Human Services (DHS) IHP program staff reported that a major focus among early IHPs was on reducing ED visits, and our results show some evidence of success in this area. DHS IHP program staff were not surprised by our lack of evidence of change in quality, particularly for year one of program participation, for which the state’s assessment of IHP performance and shared savings calculation only requires IHP reporting of quality measures (i.e., with no effect on shared savings calculations) and in year two of participation, when an IHP’s quality performance impacts a relatively small proportion (25%) of its shared savings calculation. It is possible that later years of program participation would show different results in quality (e.g., during year three, 50% of the shared savings calculation is based on an IHP’s quality performance).

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Per our First Annual Evaluation Report and Chapter 5 of the final evaluation report, IHP providers have reported changing practice patterns after participation in the IHP program, and some have reported “spillover” effects of IHP participation (including use of data analytics) on other patients seen by the same providers. Our analyses do not enable us to identify the reasons for similar utilization, cost, and quality trends for Round 1 MHCP and commercial enrollees during the first two years of program participation, but our findings do not rule out the potential for spillover of IHP-related practice changes to non-IHP patients, given these common results.

It is important to note that additional analyses by SHADAC are forthcoming in a separate manuscript. These analyses will build on the results presented in the final evaluation report through incorporation of a control group. There may be secular trends that are unrelated to the IHP program that are responsible for our observed reductions in ED use, hospitalizations, and inpatient costs among both MHCP and commercial health plan enrollees. Our forthcoming analyses will help to control for other policies or trends occurring contemporaneously with IHP implementation that would be misattributed to IHPs in estimated year-to-year changes.

Some Evidence of Triple Aim Achievements among ACHs

Many of Minnesota’s investments under SIM were aimed at advancing providers’ capacity and infrastructure in the areas of community collaboration, data analytics and exchange, care coordination, and health payment transformation. While the motivation behind these investments includes improvements in health care quality and costs, many of these programs were not expected to have effects on patient experiences, health outcomes, and health care costs during the immediate SIM initiative time window.

One notable exception to this expectation was the ACH Grant Program, through which 15 communities implemented new or advanced existing community-based care coordination approaches that directly touched the lives of patients and community members. Findings from qualitative interviews with organizations participating in these collaboratives, from ACHs’ own evaluations, and from a survey of individual providers participating in or knowledgeable about ACH care coordination approaches indicate some evidence of Triple Aim achievements.

Overall, ACH grantees and providers reported advancements in coordinated and patient-centered care. For example, one theme we heard from our ACH interviewees is that ACH community-based coordination led to improvements in care quality, including the extent to which care and services were provided in a patient-centered manner. Among ACH Provider Survey respondents, 52.5% reported that ACH care coordination services had a significant positive impact on their ability to provide quality care services, and only 3.7% reported no impact or a negative impact. Most survey respondents reported improved knowledge of patient/client medical and other needs (over 61.1%); improved appropriateness of care/services provided (78.3%); improved quality of care/services received by patients/clients (78.3%); improved provider/patient relationships (59.8%); improved management of chronic disease for patients/clients (72.4%); and improved patient/client engagement in their care (78.8%). Eight out of ten providers also reported that their ACH had helped to improve patient/client health outcomes.

Interviews with ACH partners also pointed to improvements in patient satisfaction, particularly with regard to assistance with health care system navigation and advocacy and in terms of feeling connected.
with the system. ACH Provider Survey data support ACH interviewee perceptions of enhanced patient satisfaction, with 78.5% of survey respondents reporting that patient/client satisfaction was either somewhat or much improved due to ACH care coordination.

A subset of ACHs collected their own data on service utilization and health care costs. Five of the six ACHs that assessed ED visits saw decreases in ED utilization over time (with one awaiting results). Four of these ACHs conducted care coordination anchored at a medical facility, and two ACHs initiated care coordination from within a community organization or employing a combination of medical and community-based starting points. In all, four ACHs conducted or are conducting cost analyses to determine the impact of ACH services on the cost of care. At the time this report was prepared, the results of two of these were not yet available, but the other two showed a reduction in health care costs. One examined total ED costs year-over-year for patients continuously enrolled in care coordination and found a 55% reduction in total ED costs, for a savings of $29,304. Another ACH examined total pharmacy claims before and after the ACH intervention and found a 9% drop in claims, representing a $439,674 reduction in costs. The majority of ACHs did not measure cost impacts of their work. Generally, ACHs did not have access to the claims data necessary for cost analysis. Also, some ACHs estimated that their interventions/cohorts were too small to allow for a feasible financial analysis.

**Little Momentum in Multi-Payer ACO Alignment**

One of the four aims of the Minnesota Accountable Health Model was that financial incentives for providers are aligned across payers and promote the Triple Aim goals. To achieve this aim, the state established as one of its primary drivers the standardization of ACO performance measurement, core competencies, and payment methodologies. The state originally envisioned this work to include advancing alternative payment methodologies, establishing core competencies and regulatory structures for ACOs, developing core measures for ACO cost and quality, and developing integrated ACO financial models and measures for complex patients. During the SIM initiative, the state’s key accomplishments in this area included: 1) the design and administration of the ACO Baseline Assessment, key informant interviews, and an Internet survey commissioned with SIM funds to assess the extent to which accountable care models exist in the state; and 2) the formation of the Data Analytics Subgroup under the two task forces advising the SIM initiative, with the goal of developing recommendations to promote the consistent sharing of data analytics reports between payers and providers engaged in ACO models.

During interviews with SHADAC, state executive leaders and program staff conveyed a belief that little progress towards multi-payer ACO alignment had been made during the SIM initiative. As SHADAC noted in the First Annual Evaluation Report, state efforts in this area started on a slower timeline than originally planned in part because important questions persisted about the extent and nature of ACO arrangements in the state. Multi-payer alignment efforts subsequently continued to lack momentum throughout the SIM initiative. Conditions were such that members of the Multi-Payer Alignment Task Force were “not in a position strategically to come to the table and play,” according to one state official. Such conditions contributed to an “inability to have meaningful conversations with the payer group.” Another state leader described the absence of progress as a “missed opportunit[y]...to push harder on.” In response to questions posed by SHADAC to the Multi-Payer Advisory Task Force, members reinforced this sentiment, indicating that there had been a lack of concrete movement in the alignment of different value-based payment initiatives and quality measurement systems across payers.
The dynamics that exist in the broader market in Minnesota may not be conducive to the state acting as an effective convener of multi-payer ACO alignment at this time. These dynamics were summarized by members of the two task forces when responding to questions about multi-payer state-based strategies to transition providers to APMs that were asked by CMMI as part of its RFI on State Innovation Model Concepts. In particular, the members remarked that, “Public programs in Minnesota are not a large enough base to drive payer alignment without the involvement of commercial payers, who have distinct reimbursement and quality improvement programs. The competitive nature of health plans and health systems makes it difficult for payer alignment, and including self-insured groups [in APMs], which represent a significant portion of the commercial population [in Minnesota], is also challenging....”

State staff echoed some of the above points in discussing a lack of momentum for ACO alignment activities during the SIM initiative. Specifically, they suggested that the uptake of value-based purchasing among commercial payers in the state may be happening slowly, especially with regards to the percent of revenue at risk in provider contracts; that there was mixed evidence emerging across the country as to the financial performance and quality results associated with ACOs; that there had been a lack of tangible goals for multi-payer alignment in the state under SIM given that ACOs are not currently defined or regulated under state statute; and that there was a perceived lack of leadership supporting ACO alignment outside of the public sector.

Multi-Payer Alignment Task Force members who responded to written questions posed by SHADAC had perspectives on the key barriers to alignment in the Minnesota context. They cited fragmented initiatives as the primary barrier to ACO alignment. ACOs, IHPs, Health Care Homes, and other programs were seen in many cases as conflicting, overlapping value-based models. Members felt strongly that the number of different programs using different approaches to accomplish the same goals undermines alignment for providers. Additionally, the lack of broad initiatives and relatively small market share of value-based purchasing were cited as a barrier. Members emphasized a need for large-scale programs in order to achieve meaningful system-level change. They also cited the lack of a single statewide HIE system as a barrier to managing care. In their responses, members encouraged stakeholders to work through data privacy concerns to achieve greater data sharing capability across the state.

Despite these challenges, state executive leaders and program staff maintained that there were positive outcomes from Minnesota’s efforts in the area of multi-payer alignment. A key outcome of Minnesota’s efforts in the area was an increased awareness and knowledge of the broader market, which was facilitated in part by SIM investment in the state’s inaugural ACO Baseline Assessment as well as through the state’s experience expanding and developing the IHP program. Multi-Payer Advisory Task Force members also identified the results of the ACO Baseline Assessment as an important accomplishment under SIM. Another area of progress reported by some Multi-Payer Advisory Task Force members was collaboration, both across task force members and between state agencies. Specifically, they noted that getting a range of stakeholders “around the table” for open conversations about alignment, measurement, and key barriers was critical work under SIM. Task force member perceptions were

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mixed, however, on the question of whether participation in the task force resulted in new conversations, relationships, or partnerships related to alignment at their individual organizations.

In summary, while no significant, tangible progress was or could be made under SIM in developing quality measures, core competencies, and aligned payment methodologies for ACO arrangements in the state, some progress was made in increasing knowledge of the market, engaging stakeholders around the topic, and building relationships that may help to facilitate productive discussions about ACO alignment in the future. Increased knowledge of the market also informed the ongoing development of the IHP program, where the state has leverage as a purchaser of health care services.

**New or Strengthened Relationships across Providers, Organizations, and the State**

The engagement of and the strengthening of relationships among a diverse set of providers and organizations across the state as well as within state government was an area of progress during the first year of the SIM initiative. According to state leadership and staff as well as numerous grantees and their partners, this foundational investment in relationship and partnership development continued to be a key outcome throughout the initiative. As discussed above, the state was intentional about seeking more, strengthened, and diverse relationships under SIM, with DHS and MDH identifying four priority settings and making deliberate efforts to recruit participants from these settings to participate in SIM programs and activities. These efforts included: forming the Multi-Payer Alignment Task Force and the Community Advisory Task Force; sharing information about the Model through regional meetings; building staff capacity within state agencies through community engagement and equity trainings and consultation; and strategically designing of program components and requirements. For example, the two drivers with the most significant investment of SIM dollars (the e-Health Collaborative and ACH Grant Programs) involved forming community and organization collaboratives to achieve SIM care coordination goals.

The state’s intentionality about relationship development under SIM led to success in expanding who is “at the table” (e.g., different state agencies, both larger and smaller medical providers, both medical and priority setting providers), and several state staff members and grantees considered this to be an area of innovation under SIM. New collaborations formed, and collaborations became more formalized and diverse under Minnesota’s Model. Two-thirds (67%) of organizations responding to the SIM Organization Survey reported “some increase” and 20% of respondents reported a “large increase” in the number of collaborations due to SIM. Similarly, 74% of respondent organizations reported that at least one relationship with one of the following stakeholder types became more formalized over the course of SIM: the state, SIM priority setting providers, medical providers, payers, community organizations, and clients. Of the organizations that progressed in relationship formality, most of the progressively formalized relationships were with priority setting providers, followed by community organizations, and the state (i.e., DHS and MDH). When asked about the importance of relationship building with organizations as a means of improving client or patient experience, reducing costs of health care, and improving population health, the vast majority (92%) of SIM Minnesota Organization

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13 The SIM Organization Survey asked respondents to rate formality of relationships at two points in time: before participating in SIM; and at the time of the survey, which was either during or after SIM participation. The number of organizations with responses at both points in time, excluding Not Applicable responses, was 110. Percentages are based on analysis of weighted data. Increased formality is defined as organizations reporting their relationship with a stakeholder type as farther along the scale at the time of the survey compared to before SIM. The survey scale is as follows: no relationship exists; aware of one another; informal collaboration; one formal collaboration; and formal collaboration with shared accountability for quality and cost.
Survey respondents placed either high importance on relationship building for achieving the Triple Aim or reported relationship building as “absolutely essential” to achieving the Triple Aim.

Importantly, the SIM initiative also involved a partnership between two state agencies: DHS and MDH. The state appointed, hired, or lent staff to fill positions on each of the state committees and structures to ensure that there was representation from both agencies. While collaboration is not new to these agencies, their partnership under SIM was reported as uniquely due to its size, duration, and federal oversight. In this novel scenario, two agencies with vastly different cultures and services that are accustomed to competing for state dollars collaborated for over almost five years, including on SIM proposal efforts. SIM “…took money out of the equation,” according to a discussion with state staff. The joint-agency leadership and administration of SIM, while complex and administratively challenging, resulted in mutual increased knowledge of and respect for staff working in different agencies and in different departments within agencies. Staff communicated value in learning how different agencies approach their work and in joint decision making that leverages expertise from multiple departments and agencies.

**Broadened Conversation about Health within the State**

When asked about their perceptions of SIM impacts, several Executive Committee and Leadership Team members highlighted, both in the first year of the evaluation and in our final interviews, the advancement of the “conversation of what creates health” in the state. The SIM initiative was viewed as a catalyst of a broader conversation or “shift in culture” about health and health reform in the state, and the initiative “aligned with the state’s broader [health] equity agenda.” State leaders spoke not just about the expansion of who is “at the table” but also movement toward a “common belief” among different state agencies and different types of organizations and providers that health is more than medical care and in the importance of individual, social, community, economic, and other health determinants. As one state leader stated, “We’re so busy working in the current system, in the structure we have now. We continue to allow people to dig in and stay in their own ditches….SIM has been effective at making people get out of their ditch and see the big perspective. These kinds of things offer the opportunity, provide enough oxygen to get out of the ditch.” While Executive Committee and Leadership Team members believe that while the conversation about health had already begun to change prior to SIM and would have changed without SIM funding, this change would have happened more slowly in the absence of SIM.

Representatives of health care systems/clinics and organizations participating in the Emerging Professions, Practice Transformation, and ACH Grant Programs reinforced SIM’s acceleration of a broader understanding of health in the state. Several of these individuals reported that SIM investments helped to heighten their awareness and understanding of the experiences and health and social needs of their community members and patients and to cultivate a “whole-person” approach to addressing individuals’ needs. This increase in awareness was facilitated in several ways:

- Engaging and partnering with other providers and community organizations that serve community members;
- Developing and implementing new tools for assessing individual needs;
- Engaging community members and patients in collaborative care models;
- Incorporating community care coordination staff into care models;
• Improving electronic health record (EHR) capacity and output; and
• Receiving and analyzing data reflecting patient-level clinical profiles and health care and prescription use patterns within and outside of their own systems.

Forty-nine percent (49%) of SIM Minnesota Organization Survey respondents reported progress in conducting social determinant assessments of patients/clients. The majority of individual providers responding to the ACH Provider Survey reported that the community-based care coordination services implemented as part of their ACH grant helped to improve the completeness of patient/client information they have for care planning and their knowledge of patient/client medical, behavioral health, social service and public health needs. Likewise, 48% of individuals responding to the HIE User Survey responded in a similar manner (i.e., the HIE method implemented improved the completeness of patient/client information for care planning) as part of their e-Health Collaborative Grant.

Model Sustainability and Future Considerations
Since 2015, the SIM Leadership Team has taken several steps to plan for program sustainability beyond 2017, including: participating in several planning meetings with contracted facilitator Center for Health Care Strategies (CHCS), consulting with the two SIM task forces, meeting with CMMI, and submitting a sustainability plan to CMMI at the end of the initiative. Based on this work, the SIM Leadership Team in Minnesota identified three priority areas for sustainability: 1) health information exchange and data analytics; 2) value-based purchasing and the alignment of incentives with desired outcomes; and 3) community connections, partnerships, and authentic engagement. The state is scheduled to submit a sustainability plan to CMMI at the end of the initiative.

In this section, we first summarize the status and sustainability of investments under each of the five Model drivers beyond the end of SIM funding in December of 2017. We then focus on the sustainability of a core set of DHS and MDH programs, activities, and investments, and, finally, outline possible future considerations for the state.

Sustainability of Select Model Programs and Activities
Each of the driver-specific chapters within the final evaluation report summarize the driver programs and activities that will continue, evolve, or conclude at the completion of the state’s SIM award. Findings were based on interviews, survey results, and document review as of September 2017. Exhibit ES.5 summarizes the status and continuation of activities under each of the drivers. It is important to note that the status of some activities may evolve following the completion of this report, as a number of providers and organizations have not completed their grants and contracts at the time of this writing.
Exhibit ES.5. Capacity of Model Programs and Activities Included in the Evaluation to Sustain beyond SIM Funding

<table>
<thead>
<tr>
<th>Capacity of Model Programs and Activities Included in the Evaluation to Sustain, by Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driver 1. Health Information Technology (HIT)/Health Information Exchange (HIE):</strong> Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement</td>
</tr>
</tbody>
</table>

**e-Health Collaborative Grants**
- Three of the seven collaboratives that chose an HIE service provider indicated at the time of interviews that they plan to continue to use the HIE that was implemented under SIM after their grant funding ends.
- The majority of respondents who completed the HIE User Survey, representing four e-Health Collaboratives, indicated that they want to continue to use HIE (81%) and are seeking ways to expand HIE (52%).
- The two grantees who had not made an HIE selection at the time of interviews indicated that the work done under the SIM e-health grant to build capacity for care coordination and data analytics would continue, even if they were ultimately unable to connect to a state-certified HIE.
- Several factors identified as supporting sustainability during interviews included a well-defined use case, incorporation of HIE into existing workflows, and onboarding of additional users.
- Interviewees reported the following factors inhibiting sustainability: the time commitments and costs of ongoing HIE activities, especially among rural or smaller providers; difficulty demonstrating return-on-investment (ROI); and difficulty for some providers in connecting to existing EHR-enabled networks, i.e. Epic Care Everywhere.
- E-Health Collaboratives reported early in their program implementation the lack of data standards for electronic exchange of non-clinical information, which created practical barriers to sharing data across settings.

**e-Health Roadmap**
- The E-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services was made publically available and disseminated.\(^{14}\)
- The lack of funding for Roadmap implementation raised concerns for future work. In 2017, MDH and the Minnesota e-Health Initiative indicated they would continue to support the implementation of the Roadmap in three ways: 1) monitor and share progress; 2) support priority settings and key partners; and 3) implement MDH call to action.

**Privacy, Security, and Consent Grant**
- The Foundations in Privacy Toolkit was publically available and the state reported plans to update and continue dissemination of this SIM product.\(^{15}\)

**Minnesota HIE Strategy Implementation Roadmap**
- The State of Minnesota drafted an HIE Strategy Implementation Roadmap in mid-2016 and was in the process of carrying out its three-phased approach to supporting accountable health and payment reform goals. In addition to completing a legislatively-mandated HIE study by February 2018, future state HIE investments may be in the form of grants for communities to work on ADT and care summary exchange implementation, maintenance of privacy and security resources, research on HIE ROI, and engagement of public and private stakeholders for creating shared infrastructure services for all HIOs and HDIs.

**Driver 2. IHP Data Analytics Goal:** Providers have analytic tools to manage cost/risk and improve quality

**IHP Data Analytics Grants**
- During interviews, grantees consistently noted the benefits of their capacity building, and most planned on sustaining the enhanced data infrastructure established through the grants, though future modifications may be necessary.
- While these organizations agree that the data infrastructure is to remain intact, there was less certainty among IHP data analytics interviewees regarding ongoing internal capacity to interpret and distribute data to providers in meaningful ways.

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During interviews, grantees reported that the factors enabling sustainability included data analytic projects that build on existing work and target all patients rather than those that are payer-specific. They also highlighted the importance of creating demand for the data and reporting among key leadership. The primary inhibitor to sustaining continued investment in the work begun under the data analytic grants was proving return on investment.

- The state plans to continue providing enhanced reporting and technical assistance for IHPs related to data analytics, through mechanisms such as the continued support of DHS analysts and IHP Learning Days and Data User Groups.

**Driver 3. Practice Transformation Goal: Expanded numbers of patients served by team-based, integrated/coordinated care**

**Emerging Professions Grants**
- The direct state funding distributed under the Emerging Professions Grant Program will not continue after the SIM initiative.
- According to state documentation and grantee reports to MDH as well as interviews with grantees and state staff, 79% of the Emerging Professions Integration Program grantees expressed a commitment to emerging professions in their practice. Some grantees were changing their emerging profession approach, and fewer have decided to discontinue any emerging professions presence.
- During interviews, grantees indicated that the factors enabling sustainability included the strong integration of the emerging profession practitioner into the workforce, the education and tools created under the grant program, and state support for emerging professions.
- Factors inhibiting sustainability included uncertainty around reimbursement and payment (e.g., for CHWs), the reliance on an internal champion and vulnerability to personnel changes, and the longstanding challenges to embracing change and adoption of new models.

**Practice Transformation (Round 1-3) and Practice Facilitation Grants**
- The direct funding distributed in multiple rounds of funding under the Practice Transformation Grants will not continue after the end of the program, nor will the SIM program’s ongoing guidance and monitoring of grantees. The Practice Facilitation opportunity was awarded to two vendors whose work on this intervention has been completed.
- Many of these SIM investments funded education, process transformation, capacity building, and expert input from consultants that will continue to yield benefits and influence the ongoing work of these practices. Likewise, where grant funding was used to develop new or refine existing processes, these changes were incorporated into daily work and will also continue to have a role in the ongoing work of these organizations.
- According to interviews with grantees, the successful adoption of new or improved workflows and an organizational mindset able to address system change were factors that promoted, and may continue to facilitate, sustainability.
- Grantees reported that the continuity of resources was one factor that may inhibit sustainability, as staff turnover can prevent the establishment of an internal champion from leading a consistent charge, while financial concerns can divert prioritizations and/or limit adherence to adopted system changes.
- The state will continue to support practice facilitation and transformation efforts through its delivery and payment avenues, including the HCH, BHH, and IHP programs.

**Driver 4. Accountable Communities for Health Goal: Provider organizations partner with communities and engage consumers to identify health and cost goals and take on accountability for population health**

**ACH Grants**
- The state does not plan to continue funding the ACH Grant Program beyond the SIM initiative.
According to grantee interviews, most ACHs wanted to sustain on their own but their capacity to do so was mixed. At least 11 of the 14 ACHs that wanted to sustain their projects had either secured some external source of funding (i.e., grants or reimbursement) or were working to develop the capacity to sustain all or some activities through lead/partner agency operational funding, delegation of ACH responsibilities to existing staff at lead or partner agencies, or incorporation of some activities into a BHH or HCH model. However, only six ACHs were positioned to sustain all desired activities through secured funds or existing community programs as of the time of our final interviews or, as applicable, at the time of reporting for the second quarter of 2017.

Among ACHs that may not or will not sustain activities beyond the grant period, almost all reported during interviews that they have built institutional capacity and knowledge and new community partnerships that will endure beyond the life of the grant even if they are unable to sustain ACH activities. Additionally, five ACHs reported some degree of model replication or spread that occurred as a result of the success of ACH care coordination activities, and this spread is acting as a form of sustainability.

ACHs that are sustaining tend to be located in rural areas, leverage existing or historical formal community collaborations, and be medically oriented.

According to grantee interviews, factors that influenced the sustainability of ACH activities included the ability to demonstrate success with data; collaboration and alignment with other community efforts; community, organizational, and leadership support; and access to new and multiple funding streams.

Other sustainability concerns raised early in ACH implementation included reimbursement levels for care coordination and funding for a central point person or project manager who coordinated and maintained collaborative efforts.

**Driver 5. Accountable Care Organization (ACO) Alignment Goal: ACO performance measurement, competencies, payment methodologies are standardized, and focus on complex populations**

**IHP Program**

- The 2017 Minnesota Legislature approved and the Governor of Minnesota signed into law needed legislative and funding proposals to support IHP 2.0. Efforts are in place to proceed with IHP 2.0 implementation.

**ACO Alignment**

- It is unclear whether the state will lead additional ACO alignment work in the near future.
- Future ACO alignment opportunities include the need for standardized quality measurement across existing multi-payer value-based models and alignment between state approaches and federal models.


**Sustainability of SIM Investments at the State Level**

Based on our findings across all Model drivers and on discussions with state leadership and staff, we highlight below eight key areas related to the sustainability of SIM investments in Minnesota. These key areas include the three aforementioned priority areas identified as part of the state’s sustainability planning to date. The eight areas are below:

- Value-based purchasing under Medicaid;
- The HCH program;
- The state’s support for cross-sector community collaboratives;
- Health information exchange (HIE) planning;
- Multi-payer ACO alignment;
- State-led ACO engagement;
- State development and dissemination of practice transformation resources; and
The state’s joint-agency governance structure.

**Value-Based Purchasing under Medicaid**

Under SIM, DHS expanded and refined the IHP program, and the Department stands poised to further advance the program in the future. The IHP staff and actuarial resources added under SIM have been critical as DHS has developed changes to the model (IHP 2.0), and legislation and funding necessary to implement these changes were approved by the 2017 Minnesota Legislature and signed into law by Governor Dayton.\(^\text{16}\) Specific statutory changes included a requirement for DHS to provide IHPs with a population-based payment for care coordination services that is risk-adjusted. The legislation also authorized IHPs to provide financial incentives to patients who see primary care providers for initial health assessments, maintain continuous relationships with primary care providers, and participate in ongoing health improvements and coordination of care activities. New funding was also provided to the Commissioner of Human Services to contract with HIE vendors to support IHPs in connecting enrollees with community supports and social services. Finally, the legislation provided additional administrative funding to DHS to add four more full-time equivalent (FTE) staff to support work with new contracted IHPs and for policy and administrative support related to prospective payments, HIE, and other changes aimed at strengthening partnerships with community supports and social service organizations.

**Key considerations for the advancement of the IHP program moving forward include the following:**

- Strengthening infrastructure and supports so that an even wider variety of providers—both medical (e.g., rural, independent, specialist, critical access hospitals) and non-medical (e.g., behavioral health, chemical dependency, or disability service providers)—can participate in total cost of care models;
- Creating, strengthening, and formalizing partnerships between IHPs and non-medical providers;
- Increasing clarity and further delineating the roles and responsibilities of IHPs vis-à-vis managed care organizations and the managed care delivery system;
- Aligning the IHP program, both contractually and operationally, with other value-based payment models that emerge from other payers;
- Balancing prospective payments for care management and risk-based payments tied to TCOC benchmarks; and
- Sustaining the IHP model’s trajectory of program savings and demonstrating the overall financial sustainability of the IHP model to providers, payers/purchasers, and other stakeholders.

**Health Care Home Program Adaptation**

State leaders spoke of a next generation of the Health Care Home (HCH) program benefiting from SIM experiences. Driver 3 investments, in particular, were designed to support certification and recertification of providers in the state through grants, contracts, and learning opportunities. In addition, many ACHs included an HCH partner and, while MDH did not pursue a legislative proposal in 2017 for continuation of the ACH program, several ACHs indicated in interviews with SHADAC that work began or expanded under the program will be sustained through HCH (or BHH) care coordination.

models. In addition, during the SIM initiative, the percentage of HCHs participating in the IHP program grew from 28% in the first quarter of 2014 to 67% in June 2017.\textsuperscript{17}

The state began to examine new ideas for HCH program adaptation under the NCE it received for the SIM initiative from CMMI. For example, SIM emphasis on relationship building with priority setting providers informed a new Primary Care and Local Public Health Learning Community implemented in 2017. The learning community included HCH-certified clinics and county public health and aimed to explore how health care clinics and local public health agencies can work together to achieve population health goals. In addition, findings from SHADAC’s First Annual Evaluation Report as well as recommendations of the Minnesota Health Care Financing Task Force\textsuperscript{18} reinforced concerns related to the limited funding options and reimbursement levels for care coordination. In response to this input, DHS and MDH are using SIM NCE funds to jointly support a study to quantify the cost of care coordination under the HCH program and provide information to guide future reimbursement policy.

Looking forward, multi-payer engagement in the HCH program remains uncertain. While IHP 2.0 will provide additional reimbursement for care coordination efforts of HCHs engaged in the IHP program, it will not address reimbursement concerns for HCHs that are not IHPs or for the commercially-insured patients of HCHs. With respect to Medicare, the new Quality Payment Program under MACRA gives credit to Minnesota HCH-certified Medicare providers towards their Merit-based Incentive Payment System (MIPS) scoring.

Another area of concern is the absence of grant funds in the future to support organizations in preparing for HCH certification and recertification, even with the reduced frequency of recertification from every year to every three years. Engagement strategies will need to continue to focus on harder to reach clinics, including smaller and rural clinics. The aforementioned HCH care coordination cost study may inform future engagement strategies.

**State Support for Community and Provider Collaboratives**

The SIM initiative helped to initiate and provided ongoing support for community and provider collaboratives, particularly through the e-Health Community Collaboratives and ACH Grant Programs. While the state will not continue to sponsor or administer either grant program in its current form beyond December of 2017, interviews with participating organizations indicated that several collaboratives will be able to continue their work beyond their SIM grant funding. In total, ten (66%) of the ACH grantees and a third of the e-Health Collaboratives have secured (at this time) the funding/resources to continue their initiatives at least in part. In an effort to assess collaborative sustainability, SHADAC also asked participating organizations whether the initiatives they implemented under SIM have been carried out in other parts of their organizations or have been extended to include other partners. With a few exceptions, there is modest evidence of the spread of e-Health Collaborative and ACH efforts within participating organizations or to other organizations, although several e-health grantees reported that the sustainability of their HIEs could ultimately depend on their ability to onboard additional partners. That said, even among collaboratives that have not secured additional funding/resources or have not expanded, grantees highlighted that aspects of their initiatives may

\textsuperscript{17} “Reporting Targets to CMMI,” *Minnesota Department of Human Services*, 2014 and June 2017.

prevail in the form of institutional and staff knowledge/capacities, relationships, automation, and new/revised processes and tools.

Full or partial ACH sustainability was associated with a rural location, a reliance on formal historical collaborations, and a medical orientation. Sustainability of ACH activities was facilitated by the ability to demonstrate success with data; collaboration and alignment with other community efforts; community, organizational, and leadership support; and access to new and multiple funding streams. SHADAC’s interviews with ACHs and state staff lend support to a number of recommendations for future collaborative health programs outlined in an ACH report prepared by MDH in late 2016.¹⁹

For e-Health Collaboratives, having a well-defined understanding of the intended use of the HIE was critical for implementation as well as continued use. Also, the ability to fit the new HIE approach into existing workflows was an important design and sustainability consideration. The costs of maintaining HIE activities, the challenges of competing organization priorities, and difficulty demonstrating return on investment have been challenges in sustaining the HIE work beyond the SIM funding.

**Future State e-Health HIE Strategic Planning**

The advancement of e-health, and specifically HIE, will continue to be a major focus area for the state post-SIM. As noted above, the state identified HIE as one of three priority sustainability areas in 2016, after which the state developed an HIE Strategy Implementation Roadmap outlining recommendations to guide the state’s overall work. This roadmap identified activities for state leadership, as well as other existing bodies that inform HIE work in the state, including the Minnesota e-Health Advisory Committee, the HIE Review Panel, and the Minnesota Health Information Network (MNHIN). Several of the recommendations included in this roadmap were based on lessons learned from the investments made under Driver 1 of the state’s SIM initiative.

One current activity that will inform the state’s ongoing HIE sustainability planning is the forthcoming Minnesota HIE Study, an MDH study commissioned by the Legislature to assess Minnesota’s legal, financial, and regulatory framework for HIE. The HIE Study is due to the legislature in February 2018, and it will ultimately be the guiding sustainability document for the state’s HIE work going forward. While future HIE investment priorities will be identified from the HIE Study, the state has for the time being repurposed several existing e-health appropriations to support ongoing HIE work such as grants to communities to work on implementing Admit Discharge Transfer (ADT) alerts and exchanging care summary documents (e.g., Continuity of Care Documents or CCDs), and research grants to the provider community to evaluate the return on investment for implementing HIE. The state will also continue the privacy and security work begun under SIM, including updating the SIM-sponsored online Foundations in Privacy Toolkit with new resources and disseminating toolkit findings.

The composition of Minnesota’s state-certified HIE service provider market, including what services they provide and which organizations they connect to, will likely be one major factor affecting the ongoing work of the state in the area of HIE. A second factor will be the state’s role recommending policy and regulatory changes to advance HIE.

Looking ahead, the SIM initiative in Minnesota has demonstrated the importance of defining exactly what product or HIE capability is desired by health and health care providers and payers in order to improve individual and community health. It appears many provider organizations and HIE service providers are looking to the state to advance HIE by defining specific use cases and linking those to tangible goals and business requirements. Overall, state staff indicated a sense of momentum developing around e-health as a result of SIM, which it expects to continue.

**Multi-payer ACO Alignment**

The foundation has been laid for informed discussions among payers and providers regarding standardized performance measurement, competencies, and payment methodologies for ACOs as a result of SIM, but it is unclear whether the state will lead additional ACO alignment work in the near future. The dynamics that exist in the broader market may not have been conducive to the state playing an effective role as convener or broker of multi-payer ACO alignment during SIM, and this may continue to be the case moving forward.

Looking ahead to future ACO alignment opportunities, Multi-Payer Alignment Task Force members who responded to questions from SHADAC about ACO alignment emphasized a need for programs to be large-scale in order to achieve meaningful system-level change and for quality measurement to be standardized across multi-payer value-based models. Respondents also emphasized the importance of making sure that state approaches align with federal models, including the Quality Payment Program (QPP) under MACRA. According to amended Minnesota statute, the legislature is calling for the development of a new measurement framework by June of 2018 “that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the role of stakeholders.” By December 2018, the framework will inform updates to the Statewide Quality Reporting and Measurement System (SQRMS). State staff reported that the work accomplished under SIM has the potential to inform the development of the framework.

Other areas that members highlighted as important for standardization included interoperable health information exchange and a shared understanding of what an effectively integrated system would look like. There was also concern about ensuring that reliable data for value-based payment and delivery system reform continue to be generated and maintained as the system shifts away from fee-for-service, since a large share of existing data infrastructure is based on claims data generated through the fee-for-service system. Task force members noted that any future standardization should be balanced with flexibility, particularly with regard to how shared goals—such as effective integration—are achieved.

The task force members expressed mixed opinions about the role the state should play in sustaining and advancing progress on ACO alignment in the future. The importance of aligning incentives, focusing on data sharing and uniformity, and engaging MCOs through the IHP program were cited as opportunities for sustaining momentum. However, task force members also raised concern about the impact that the changing federal policy environment may have on the ability to sustain and advance progress on alignment goals.

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It is unclear whether the state will lead additional ACO alignment work in the near future. Future efforts will need to consider barriers experienced during the SIM initiative. Among several, these included a need for more clarity around alignment goals, fragmentation of existing public and private initiatives, the competitive nature of health plans and health systems, lack of ACO definition and regulation in the state, and a need for leadership supporting alignment across both private and public sectors.

State-Led Community Engagement

Minnesota employed a variety of strategies to engage payers, medical and non-medical providers, community organizations, and state agency staff to participate in the Minnesota Accountable Health Model. These approaches included sharing information about the Model; seeking guidance on the initiative (e.g., via the task forces); supporting relationships between state agencies and external organizations and within and across state agencies; building staff capacity within state agencies through training and consultation; awarding grants to organizations and communities across the state and providing flexibility for grant recipients to design and implement unique reform models tailored to local circumstances; focusing program development on priority setting providers and involving community members; and promoting health equity policy.

As part of the state evaluation, Rainbow Research prepared a report\(^{21}\) on state-led community engagement and partnership activities under SIM and—based on interviews they conducted with state staff and stakeholders—summarized several recommendations for the state. A key point highlighted by Rainbow Research is that engagement and partnerships “take focused, ongoing commitment.” ACHs, e-Health Collaboratives and other grantees reiterated this point in interviews with SHADAC, and, in fact, it was a key issue to surface in the First Annual Evaluation Report.

Rainbow Research outlined the following recommendations based on its interviews with stakeholders for future state-led community engagement:

- Fully commit to community engagement within MDH and DHS through dedicated strategy, funding, and staffing, and make community engagement “foundational to every aspect of the state’s work”;
- Increase state staff capacity to engage communities and build partnerships (e.g., related to who and how);
- Focus sustainability efforts on successful community engagement approaches; and
- Continue to build trust in the community as trust is “integral to doing authentic community engagement.”

Future engagement can focus on maintaining connections with stakeholders who participated in the SIM initiative as well as engaging new stakeholders who were not actively or directly involved in SIM, including: a subset of private purchasers; long-term, post-acute and/or home care service providers; some provider associations; some state and county government offices; and consumers. The SIM Organization Database developed by SHADAC as part of the state evaluation could serve as a useful resource in the state’s future engagement efforts.

Resources to Support Future Accountable Care Reform Efforts
Minnesota used SIM funds to make direct investments to medical and priority setting organizations and collaboratives across the state as well as to make “support” investments to vendors/consultants and state agencies charged with assisting the transformation of organizations and collaboratives. Many of these support investments resulted in products that can and are envisioned to serve as ongoing resources to assist organizations in their transformation efforts in the future and to reach not only organizations that participated in the SIM initiative but also other organizations and stakeholders throughout the state. Available online for broad access and use, these resources are important mechanisms for sustaining and spreading the progress made and knowledge generated under the SIM initiative. These resources include: an e-Health Roadmap for priority setting providers; a privacy toolkit; emerging professions toolkits; learning collaborative materials; Minnesota Accountable Health Model Continuum of Accountability assessment tool; community engagement materials; and materials from this state evaluation. Also under development are e-Learning Training modules for IHPs, BHHs, and HCHs as well as a directory of SIM-funded programs.

SIM Governance Structure in Minnesota
SHADAC interviews with state staff confirmed that the SIM Executive Committee, Leadership Team, and Core Workgroups will disband formally after the SIM funding ends. The two task forces advising the state on the SIM initiative have also ended and met for the last time in the spring of 2017. Many of the state employees who were assigned to or hired to work on the SIM initiative will continue in other roles or return to their previous positions and take SIM knowledge and relationships with them. For example, several SIM project leads or managers will continue at DHS supporting a new area under Policy Development and Implementation within the division of Health Care Administration. This area is the home of Minnesota Medicaid’s behavioral health home services.

State managers and staff have new and strengthened relationships and contacts across agencies due to SIM, and staff reported already leveraging cross-agency relationships. For example, DHS staff consulted with MDH staff on the IHP Encounter Alerting Service Vendor request for proposals, and MDH sought input from DHS staff on the current HIE study. Other opportunities for cross-agency collaboration will continue such as MDH’s and DHS’s representation on the e-Health and HCH Advisory Committees and the Administrative Uniformity Committee (AUC). MDH and DHS will also continue with an Inter-Agency Agreement (contract) in which a full-time staff person is paid for by DHS but resides at MDH and supports behavioral health integration and behavioral health home services.

State leadership spoke of the need for intentional organizational changes to sustain the progress made under SIM in terms of state agency structures (e.g., job descriptions) and coordination within and across state programs. For example, Executive Committee members spoke of incorporating a health and health equity lens in diverse state programs, better coordinating the distribution of state funding, and developing cross-agency or cross-program blended requests for proposals.

The Minnesota Accountable Health Model term was the umbrella term for all of the state’s work under SIM and its five drivers, and state leadership reported that this term will not continue to be formally used by the state. While the term was meant to show “we are trying to all go in one direction,” it was never as well known in the state as the “SIM” acronym and will likely disappear over time.
Conclusion

Minnesota’s four-year SIM initiative, the Minnesota Accountable Health Model (the Model), comes to an end in December 2017. With these federal funds, the Minnesota Department of Human Services (DHS), together with the Minnesota Department of Health (MDH), made significant investments in health information technology (HIT) and Health Information Exchange (HIE); the size and capabilities of the Integrated Health Partnership (IHP) program; person-centered, coordinated care and Health Care Home (HCH) and Behavioral Health Home (BHH) readiness among providers; engagement of and relationships between and among medical and non-medical providers, especially behavioral health and social services providers; and understanding the multi-payer Accountable Care Organization (ACO) landscape in the state.

Key accomplishments and outcomes across Model investments are as follows:

- The state expanded and advanced its Medicaid ACO program and was viewed by IHP provider systems as a leader among payers in data analytics and reporting.
- The number of SIM-collaborating organizations participating in alternative payment arrangements (APMs) increased over the period of the cooperative agreement, but this increase was primarily in the Medicaid market.
- SIM e-health investments increased provider connections to the state’s HIE infrastructure and augmented statewide HIE vendor capacity.
- State practice transformation programs and activities under SIM placed emerging professions practitioners in select front-line work settings; led to improvements in the capacity of participating providers and organizations to deliver coordinated care across settings; supported new and existing HCHs; and facilitated the successful launch of BHHS.
- ACH community-based care coordination led to improvements in care quality and patient outcomes, and individual ACH evaluations provided some evidence of cost savings.
- The state developed knowledge of the ACO market, engaged public and private sector stakeholders, and built relationships that may help to support future discussions about ACO multi-payer alignment.
- Through joint-agency leadership, intentional stakeholder engagement, and the distribution of grants across the state with the flexibility to support innovative local reform models, DHS and MDH fostered new and strengthened relationships across sectors within the state, and broadened the conversation about health to one that goes beyond the medical care system to consider community characteristics and social determinants of health.

Although the infrastructure built around the SIM initiative will be disbanding with the federal funding, it is clear that Minnesota’s SIM investments have left their mark on the state and among provider communities in several key ways. The IHP program is pressing forward with new provider capabilities and new program enhancements stemming from SIM investments and lessons, and the state’s HCH program is adapting to encourage more providers to become certified and re-certified. Over half of the ACHs and a third of e-Health Collaboratives have secured funding/resources to continue their initiatives in some form. The state is well-informed and positioned to continue to advance e-health through its HIE Strategy Implementation Roadmap. A number of new capabilities and resources now exist that can
provide future support to organizations across the state in their transformation to accountable care and community engagement efforts.

Key considerations for the future include:

- continued engagement of a variety of both medical and non-medical providers in state models, (e.g., the IHP and HCH programs), including the harder to reach organizations or those that are not as far along in their transformation to patient-centered, coordinated and/or integrated care;
- continued support for provider organizations on the journey to accountable care and monitoring of practice transformation efforts;
- further study of the impact of state models on quality and costs and their overall viability over time;
- identification of the state’s future HIE investment priorities based on its legislatively mandated HIE study, including specific use cases linked to tangible goals and business requirements;
- discussion of future alignment efforts across state multi-payer, value-based or alternative payment models that is informed by the SIM experience.

Ultimately, through this massive effort, the state progressed toward its original SIM aims of achieving a health care system that: provides patient-centered, coordinated care; holds providers accountable for costs and quality of care; aligns financial incentives to promote the Triple Aim; and implements collaborative approaches to set and achieve health improvement goals.