III. STATE HEALTH CARE INNOVATION PLAN

1. Vision statement for health system transformation in Minnesota

The state of Minnesota has a national reputation and proven ability to develop and implement homegrown innovative models of care founded on our history of collaboration among payers, providers, and communities to provide a high quality of care to Minnesotans. Frequently cited as a model for health system efficiency, Minnesota ranks among the top in the county in overall population health, and our providers rank among the most effective and efficient in the country, as shown in the Dartmouth Atlas analysis[1]. Further evidence of Minnesota's health systems effectiveness was recently demonstrated in the Commonwealth Fund's Scorecard on Local Health System Performance, which ranked 4 of Minnesota's local areas (St. Paul (1st), Rochester (3rd), Minneapolis (4th), and St. Cloud (7th)) in the Top 10 in the country for overall system performance.[2]

Minnesota has a long history of providing good access to quality health care for all of its citizens and requiring a high bar for quality for providers and health plans. We have one of the nation's lowest rates of uninsured. The state also enjoys a health care system where both provider organizations and health plans work collaboratively to improve health care services and health outcomes of our populations, such as requiring statewide reporting on quality measures, credentialing, evidence-based decision-making and reducing hospital readmissions.

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[1]The Trustees of Dartmouth College (2012). The Dartmouth atlas of health care: data by region. Retrieved from http://dartmouthatlas.org/data/region/profile.aspx?loc=25

[2] The Commonwealth Fund Commission on a High Performance Health System (2012). Rising to the challenge: results from a scorecard on local health system performance. Retrieved from http://commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Mar/Local%20Scorecard/1578_Commission_rising_to_challenge_local_scorecard_2012_FINALv2.pdf

While Minnesota consistently ranks as one of the healthiest states in the nation, health care costs are increasingly unaffordable and there is significant variation in the quality of care across the state. Recognizing what is at stake, the state's health care community — payers, providers, consumers and advocates alike — is prepared to innovate and reform, but success is contingent on having the additional resources and infrastructure necessary to support this transformation.

The Minnesota State Innovation Plan is a five-year plan to work with our health care providers, payers, public health agencies, ancillary services providers, and communities to create system wide transformation — through the implementation of accountable care organization (ACO) models — that will meet the goals of the Triple Aim: improved population health, improved patient experience, and lower costs. Minnesota is in a strong position to leverage our health care delivery innovations and the state's Medicaid program as a large payer of health care services to drive providers toward evidence-based models of accountable care, giving them the tools necessary to support improved coordination and integration of services, ultimately resulting in better quality of care and patient health, at lower cost.

The Innovation Plan lays out a roadmap that uses three primary strategies to achieve these goals:

1. Implementation and expansion of payment reform based on the principles of accountable care

2. Implementation of community integration models to enhance the reformed payment system

3. Foundational investments in infrastructure that will give providers tools to form new partnerships, securely exchange data, improve quality and reduce costs.

The Problem of Fragmented Systems with Misaligned Incentives

The Minnesota Accountable Health Model supports the transitioning of providers away from the current fee-for-service model, which rewards volume over value, and toward a more rational system that rewards high quality and efficiency. Current payment methods that rely on fee-for-service and that encourage use of care (operations, procedures, tests) do not facilitate efficient resource utilization by providers, focus on the quality of care nor incentivize providers to organize care around the needs of their patients. They also do not encourage coordination and integration of care throughout the system, attention to and investment in prevention, or meaningful patient engagement in or ownership over their care. At a broader community level, different organizations and actors — local public health agencies, community or culturally based organizations, social services agencies, schools — focus on different aspects of population health or well-being, but often do not have mechanisms in place to integrate care, share data or coordinate their activities.

Addressing these challenges will require fundamental changes in provider payment and methods of delivering care, and consumer and community activation to build healthier lives and healthier communities. Consumers, employers, providers, health plans, government and other stakeholders all have essential roles to play to effect this transformation. Through this Innovation Plan, and the Minnesota Accountable Health Model that is at its heart, the state proposes to reform the payment system and shift provider incentives toward improvements in quality and reductions in cost. At the same time, the Plan and the Model give providers the freedom and support necessary to foster innovation within the delivery system to determine the most efficient and effective means of providing care and improving health and provide the opportunity to replicate these innovative care models across the state of Minnesota.

Minnesota's Innovation Plan recognizes that more than 70 percent of health is determined by factors outside of the health care system[3] and focuses on creating a path to Accountable Communities for Health (ACH). ACHs will provide replicable models in which the traditional health care system is fully integrated across acute care, primary care, mental health, substance abuse, and long-term care as well as with other local, community-based public health, social service and educational systems designed to address the social determinants that impact the health of Minnesotans. Together, these approaches hold the potential to dramatically change not only how, where and by whom care is delivered, but also the outcomes that they achieve.

Building on what's working in Minnesota

The Innovation Plan specifically builds on and accelerates the ACO arrangements currently under way in Minnesota among commercial payers and Medicare by expanding these arrangements to the Medicaid population. The commercial market in Minnesota has already made great progress toward the provision of value-based care through the implementation of ACO models. Based on a survey conducted in August 2012 under the auspices of the Governor's Health Reform Task Force, health plans in the commercial market reported between one-third and two-thirds of covered lives or spending associated with accountable care contracts, with higher percentages in the Twin Cities region than elsewhere in the state.

However, far less progress has been made in the Medicaid market. Minnesota will leverage its position as a larger payer of health care services under the Medicaid program using its ACO model (Health Care Delivery System (HCDS) demonstration) and other payer ACO initiatives as the foundation to move toward greater provider accountability for population health, care

[3] McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, *21*(2), 78-93.

delivery, and cost. Over time, the state will expand ACO models to other providers inside and outside the traditional health care system while continuing to align its methodologies with other payers to drive statewide system transformation. The state proposes to expand the HCDS demonstration, in collaboration with other payers, by increasing the number and types of participating providers, by expanding the scope of services for which the providers will assume responsibility to include mental health and long term care supports and services, and by aligning with other payers.

By thoughtfully expanding the scope of services for which providers will be accountable, Minnesota aims to foster better integration of care (health care, behavioral health, long-term care and waivers services); coordination and/or integration with community services, social services, and public health; and engage consumers in their health and the health of their community; and provide necessary investments and supports for providers with higher barriers to entry to or inclusion in ACO models.

The alignment of payment models that hold providers accountable for care by Medicaid, Medicare, and commercial payers will create an environment in Minnesota in which:

- Every patient receives coordinated, patient-centered primary care.
- Providers come together under a model that makes them accountable for the care provided to all patients, including Medicaid enrollees, through based on quality, patient experience and cost performance.

- Financial incentives are fully aligned across payers and with the interests of patients, through payment arrangements that reward providers for keeping patients healthy and improving quality of care.

- Participating organizations are given incentives to partner with community organizations to create Accountable Communities for Health that integrate medical care with behavioral health, mental health, public health, long-term care, social services, and other providers and share accountability for population health.

Filling in the gaps

While payment reform will shift the incentives for providers and encourage them to re-organize the way that care is delivered, without significant support for this transformation, many providers will fail to achieve the promise of accountable care. Many providers (especially small and rural providers) across health care, mental health, chemical health, community health, long-term supports and services, and social services do not currently have the technology or business practices necessary to redesign their delivery system, integrate care and services with other providers, and coordinate care around patients' needs.

In addition to shifting provider incentives through payment reform, a primary focus of the Minnesota State Innovation Plan is to give the providers the tools that they need to succeed under the accountable care model. Specifically the state will use Innovation Center funding to provide that following investments to support and enhance the Minnesota Model:

- Data analytics and quality reporting

- Electronic health records and health information exchange between providers, community resources, the state, and care teams
- Implementation of quality improvement activities
- Standardized and common quality measures and performance targets across public and commercial payers
- Support for practices that wish to transform into Health Care Homes
- Models that integrate health care, mental health, chemical health, and long-term supports and services
- Small and safety-net provider start-up costs needed to support patient-centered primary care and integration with services outside of health care
- Support for integration of new providers, such as community health workers, community paramedics, and advanced dental therapists into clinical practices.

Because policy and program interventions aimed at providers will only impact one of the many potential levers for change, the Minnesota State Innovation Plan also focuses on increasing consumer and community engagement in health care transformation to ensure that reforms and innovation meet the needs of patients and communities. Recent community discussions on health as part of the Governor's Health Reform Task Force[4] showed that Minnesotans want to take an

[4] Information on the Governor's Health Reform Task Force, including membership, workgroups, and planned deliverables is included as Appendix One.

active role in co-managing their health. Our State Innovation Plan follows these Principles for Action[5]:

1. Empower citizens to be co-creators and co-managers of their health.

2. Equip Minnesotans for healthy choices within the health system, including affordable health care.

3. Align systems and environments to encourage health.

A Pathway to a Transformed Health Care System

The Minnesota Accountable Health Model will leverage the following ACO models in its Medicaid program in partnership with other payer ACO arrangements to drive delivery system transformation: 1) the Health Care Delivery System (HCDS) demonstration, which aligns with ACO models from other public (e.g. Medicare Pioneer ACO and Shared Savings Programs) and private payers creating financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services; and 2) the continued work of the Hennepin Health demonstration ("safety-net ACO") which provides an integrated care delivery model of health care, behavioral health, and social services. Throughout the testing period, Minnesota will focus resources on developing and improving quality metrics that can support rapid cycle improvement; to assure improvements in health as the result of the model's implementation can be adequately assessed. The state will pursue the following steps under the Minnesota Accountable Health Model, also represented in Appendices 1a and 1b:

[5] Citizen Solutions (2012). Public conversations & public solutions: making health and health care better in Minnesota. Retrieved from http://health.citizensolve.org/data/projects/citizen-solve-health/Citizen-Solutions-Engagement-Results.pdf

1. **Expand ACO models to a greater number or providers and services.** With the nine contracts that begin in 2013, ACOs participating in the Medicaid HCDS and Hennepin Health demonstrations are estimated to serve approximately 25% of the non-dual Medicaid population. In Phase Two, DHS will expand ACOs (in collaboration with other payers) to include a greater number of providers with the goal of covering 50% of the non-dual Medicaid population after the Model test period, with particular focus on small providers, safety-net providers, and providers outside of Minnesota's larger integrated health care systems. In Phase Two, DHS will also expand the services that providers are held accountable for, to include services such as intensive mental health, long-term care, and home and community-based services to encourage providers to engage, coordinate, and share in financial accountability with other parts of the system, which will allow for better care that is focused on the person and reduce the "true" total cost of health care as opposed to shifting costs.
2. **Allow for flexibility of models to fit needs of communities**. The Minnesota Model will focus on allowing providers and communities to innovate and test new models of care, rather than relying on a one-size-fits-all approach. The Model will allow flexibility in the organizational requirements for ACOs, utilizing and improving on local models of care delivery transformation. ACO contracts offered through the HCDS demonstration will incentivize providers and measures outcomes but participating organizations will be able to develop care delivery models that respond to the incentives of the ACO contracts and are optimized for their patient population and local needs. Accountable Communities for Health are explicitly set up to be guided by local needs assessments, with wide flexibility in determining which community organizations to partner with and which services to

prioritize, as well as how to integrate various health care streams and determine financial allocations.

3. **Extend models beyond health care to create a greater degree of accountability across both health care and social services**. Currently, there are no existing models in other states that create financial and outcome accountability across both health care and social service delivery. While the implementation and testing of an integrated Accountable Community for Health model will be complex, it would create less siloed and more logical accountabilities, and place Minnesota clearly at the lead of innovative Medicaid solutions nationally. Phase Three of this plan will focus on expansion of the Accountable Communities for Health model, and testing of its effectiveness in driving accelerated improvements in cost, quality, and patient satisfaction.
4. **Continue to develop and foster models that focus on people with complex conditions and needs**. As a payer of services for some of the most vulnerable individuals in the state, DHS will continue to focus on assisting provider organizations in implementing delivery system models that provide better care management and coordination for individuals (and their families). These populations are often small in number but account for a significant portion of overall spending. The state will expand models, such as Minnesota's Health Care Home program, that target the unique needs of these populations and ensure their care is integrated and coordinated within the larger health care system.

These care and payment models and infrastructure investments will provide Medicaid enrollees and other populations (through multi-payer collaboration and alignment) with more coordinated and integrated care that focuses on their specific needs and health outcomes. Traditionally, health

outcomes for Medicaid enrollees lag behind those for commercial populations; by aligning its efforts with those of other payers, the state can drive delivery system transformations that help to turn the curve on cost and quality for Medicaid. These strategies, taken in combination, will accelerate the transitions already under way in Minnesota toward accountable care organizations and greater care coordination and care integration, leading to improved patient experience, improved care outcomes, and, ultimately, improved population health — at lower cost.

The State Innovation Plan builds upon a number of payment and care delivery reforms that are already underway in Minnesota. These programs will provide practices with the tools, funding, and support necessary to reform the organization and delivery of care in ways that will enable them to thrive in an ACO environment. The current activities that will complement and support the state's testing model include:

- **The multi-payer Health Care Home initiative:** Since 2010, 190 Minnesota primary care clinics have become certified as Health Care Homes. Health Care Homes (HCHs) provide coordinated, patient-centered care to nearly 2 million Minnesota patients. Maps of HCHs statewide and by county are available in Appendix 2. To be certified as Health Care Homes, a clinic must agree to establish quality improvement teams; participate in learning collaboratives; and meet standards for access/communication, patient tracking, and registry development, care coordination, development of care plans, and performance reporting and quality improvement. Health Care Homes receive risk-stratified care coordination payments from Medicaid, the state employee insurance program, and private payers. All of the nine organizations that will receive initial HCDS contracts have certified Health Care Homes as part of their system or HCDS. The state anticipates that

as more providers move to adopt ACO contracts, they will similarly choose to participate in the state Health Care Homes initiative.

- **Medicare ACOs:** Minnesota has three Pioneer ACO participants (Allina, Park Nicollet/HealthPartners, and Fairview Health Services) that are building on their existing experience with ACO contracts to include Medicare beneficiaries. Through the Pioneer ACO program, these Minnesota organizations are testing higher levels of shared savings and risk as they move a substantial portion of their payments to a population-based model, focused on coordinated patient care. In addition, Essentia Health is participating as an Accountable Care Organization in the Medicare Shared Savings Program, including its group practices, critical access hospitals, and a rural health clinic. All four organizations that are developing ACOs also will participate in the Health Care Delivery Systems (HCDS) demonstration, which will be implemented in Phase One of the testing model plan. The alignment of the Health Care Delivery Systems program with Medicare ACO development has enabled the these organizations to align Medicare payment with Medicaid ACO contracts, creating system-wide payment and delivery change that meets the needs of their specific patient populations statewide.

- **Commercial ACO contracts:** The state surveyed Minnesota health plans during the summer of 2012 regarding the extent of their current ACO contracting activity. This information, coupled with publicly available information,[6] has revealed the following:

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[6] Bailit, M. H., Hughes, C., Burns, M., and Freedman, D. H. (2012). Shared savings payment arrangements in health care: six case studies. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1624_Bailit_shared_savings_payment_arrangements_six_case_studies.pdf

- Within the commercial market, health plans report between one-third and two-thirds of covered lives or spending associated with ACO contracts, with higher percentages in the Twin Cities region than elsewhere in the state.

- Within the Medicare Advantage and Medicaid markets, health plans also report use of ACO contracts. Prevalence for Medicare Advantage and Medicaid appears to be highly variable across plans, and perhaps generally lower for Medicaid than for commercial business.

- Most ACO contracting arrangements appear to be "upside only" for provider organizations, although there are mixed upside/downside arrangements.

The state will include commercial payers on the state's Multi-payer Alignment Consultation Group, which will work to ensure alignment between the state's ACO models (HCDS and Hennepin Health demonstration programs) for the Medicaid population and commercially driven ACO contracts.

- **Duals Demonstration:** Under the *Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility* demonstration, Minnesota will implement a new purchasing and care delivery model for enrollees who are dually eligible for the Medicaid and Medicare programs. Under the umbrella of the duals demonstration, DHS will implement several service delivery and risk/gain sharing arrangements designed to align with statewide payment and delivery reforms, and to improve accountability for care outcomes across providers and service settings. While the dually- eligible population will not be included in the HCDS demonstration, the state will work to align the initiatives and provider incentives implemented for the dually eligible

population under the duals demonstration with the HCDS demonstration for the Medicaid only population. More information on the duals demonstration is available in Appendix 3.

- **Reducing Avoidable Readmissions Effectively (RARE):** As part of its Partnership for Patients grant, Minnesota is tackling the issue of readmissions through an increasing focus on coordinated transitions of care between acute and long term care settings. The RARE campaign, which launched in January 2011, has contributed to a 13 percent decrease in avoidable readmissions to participating hospitals relative to expected numbers. One of the ways that provider organizations will succeed under the ACO contracts is by reducing the number of avoidable readmissions. The RARE campaign is one example of a successful initiative that the state will encourage organizations that adopt HCDS contracts to consider when determining how to be meet the budgetary requirements of the contract. More information on the Partnership for Patients, including RARE is available in Appendix 4 and Appendix 5.

- **Medicaid Incentives for Prevention of Diabetes:** The primary prevention goal of the Minnesota Medicaid Incentives for Prevention of Diabetes targets weight loss as the gateway to long-term reductions in diabetes, improved cardiovascular health, and reduced health care expenditures. Working with the state health department and the local and national YMCAs, the state Medicaid program will enroll Medicaid beneficiaries between the ages of 18 and 75 who live in the Twin Cities metro area, and who have been diagnosed with pre-diabetes or who have a significant risk of developing Type 2 diabetes. The program, taught by certified YMCA coaches, will work with the state's certified health care homes to identify participants and offer them the opportunity to participate at

no cost and receive health-related incentives. More information on the program is available in Appendix 6.

- **Health Care Innovation Awards:** Minnesota is proud to have six awards being implemented in the state, ranging from community health to intensive care, that are all aligned with the State Innovation Plan. The State Innovation Plan and Minnesota Accountable Health Model will benefit from the knowledge and breadth of innovation represented in the Minnesota awards.

    - Two initiatives (Courage Center and Institute for Clinical Systems Improvement) build on the multi-payer Health Care Home model and test community-based initiatives to better serve populations with complex needs, including adults with disabilities who also have complex health conditions and high-risk patients who have depression with diabetes or cardiovascular disease. More information on these models is available in Appendix 7 and Appendix 8.

    - Mayo Clinic is improving critical care by reducing preventable treatment errors in intensive care units.

    - The YMCA of the USA will be implementing the Diabetes Prevention Program in Minnesota communities, in alignment with the Minnesota Medicaid Incentives for Prevention of Diabetes described above.

    - Sanford Health is focused on full integration of primary care and behavioral health care to improve outcomes and efficiency.

- Trustees of Dartmouth College will collaborate with Minnesota providers to support shared decision making through patient and family activators.

All of these initiatives provide new training for practicing health care providers or train new providers to maximize resources. The models of care represented in the Innovation Awards will inform the State Innovation Plan and Minnesota Accountable Health Model as all of these efforts develop. Specifically, the awardees will each present their findings at state-led learning collaboratives and share their experiences with the organizations participating in the testing model program.

The Minnesota Accountable Health Model

The Minnesota Accountable Health Model will build on the Medicaid ACO models--Health Care Delivery System (HCDS) program, which align with Medicare ACO models and the integrated care delivery network of Hennepin Health—along with private payers to create financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services. A visual representation of the patient-centered care that is being built in Minnesota through Hennepin Health, HCDS and Health Care Homes is provided in Appendix 1c. The ACO payment methodology seeks to move providers that are ready and have demonstrated Triple Aim achievements through their model to a prospective risk-based payment by introducing downside risk in years 2 and 3 toward development of a prospective payment. This change will provide the upfront funding providers need to make iterative changes to their delivery system models with flexibility to move resources to better meet the performance outcomes in their contracts.

1. Population demographics of Minnesota

A. General state demographic information

Minnesota is largely a rural state with a population of approximately 5,344,861.[7]

More than half of this population, however, resides in the Twin Cities metropolitan area in the east-central region of the state. Minnesota's population grew by 7.8 percent between 2000 and 2010. Most of the population growth occurred in Minnesota's suburban counties as rural areas of the state mirror the nation in losing population.

Minnesota's population is gradually diversifying. In 1990, populations of color and American Indians in Minnesota represented just over 6 percent of the total population. By 2010 that share had grown to 15 percent. The Hispanic population grew by 364 percent during that time, and the African-American population grew by 189 percent. In 2025 the state's population of color is expected to be around 22 percent, and in 2035, if this trend continues, it will reach about 25 percent.[8]

The state's diversity is increasing primarily through immigration. Minnesota attracts a wide range of immigrants to the state from other parts of the United States and from other countries,

[7] U.S. Census Bureau (2011). State & county quick facts: Minnesota. Retrieved from http://quickfacts.census.gov/qfd/states/27000.html

[8] Martha McMurry (2009). Minnesota population projections by race and Hispanic origin, 2005 to 2035. Minnesota State Demographic Center, Department of Administration. Retrieved from http://www.demography.state.mn.us/documents/MinnesotaPopulationProjectionsbyRaceandHispanicOrigin2005to2035.pdf

who move here to attend school, start businesses, work in Minnesota industries, and join family members. Minnesota's diversity is quite varied when considering places of origin. Minnesotans include new residents from Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan, to name just a few. This diversity within racial and ethnic categories (especially from Asia and Africa) presents nearly as many challenges as diversity within the whole population. For example, at least 19 different countries are represented among Asian immigrants to Minnesota. The growing diversity of Minnesota is not limited to its urban areas; some rural regions of Minnesota, in particular the southwest, have also experienced dramatic increases in immigration.

Consistent with the demographic shifts occurring throughout our country, Minnesota's population is aging. From 2000 to 2010, the proportion of Minnesotans under the age of 45 decreased by 2 percent while the proportion of individuals 45 and older increased by 27 percent. The largest increases in Minnesota's population from 2000 to 2010 were in age groups 50 years and older. The proportion of the state's population over 65 will increase as the baby boomer generation continues to move toward retirement age; between 2000 and 2030, the 65-year-and-older age group is expected to increase by almost 700,000, a rate of 117 percent.[9]

This shift in demographics is particularly acute in rural areas of Minnesota, where the aging population is expected to grow more quickly than in the metropolitan area. The proportion of older residents is expected to be largest in Minnesota's rural western and northern counties.

Income/Wealth Disparities in Minnesota

[9] Minnesota Department of Health (2009, January 15). Health workforce shortage study report: report to the Minnesota Legislature 2009. Retrieved from http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf

In Minnesota, African-American and American Indian populations have household incomes that are less than half that of Asian and white populations.[10] Nearly two-thirds of African-American Minneapolis-St. Paul residents, compared with about one-fourth of the cities' white residents, live in "asset poverty," meaning they do not have enough assets to live above the poverty level for three months if they lose their main source of income.[11]

Poverty among Minnesota's children is also not evenly distributed. A far-greater percentage of children of color live in poverty than white children. And children who grow up in poverty are very likely to remain in poverty as adults. In 2010, 10 percent of white children under 18 lived below 100 percent of the federal poverty level, compared with 45.9 percent of African-American children, 56 percent of American Indian children, 23.7 percent of Asian children, and 29.3 percent of Hispanic children.[12]

Rates of home ownership vary widely by race and ethnicity in Minnesota. A recent analysis of Minneapolis and St. Paul revealed that more than 60 percent of the white population in the Twin Cities metropolitan area owns a home, but barely a quarter of the African-American and American Indian populations in Minneapolis and St. Paul are homeowners. [13][14]

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[10] U.S. Census Bureau, 2011 American Community Survey (2011). Selected economic characteristics, 1-year estimates. Retrieved from http://factfinder2.census.gov

[11] Luechtefeld, S. (2011). *CFED research release highlights Twin Cities' financial insecurity* [Blog post]. Corporation for Enterprise Development. Retrieved from http://cfed.org/blog/inclusiveeconomy/cfed_research_release_highlights_financial_insecurity/

[12] U.S. Census Bureau, 2011 American Community Survey (2011). Selected economic characteristics, 1-year estimates. Retrieved from http://factfinder2.census.gov

[13] Corporation for Enterprise Development (CFED) (2011). *Assets and opportunity profile: Minneapolis*. Retrieved from http://cfed.org/assets/pdfs/minneapolis_ao_profile.pdf

[14] Corporation for Enterprise Development (CFED) (2011). *Assets and opportunity profile: St. Paul*. Retrieved from http://cfed.org/assets/pdfs/stpaul_ao_profile.pdf

B. Medicaid and CHIP population

Minnesota's Medicaid and CHIP program operates in a single program called Medical Assistance (MA) and serves a monthly average of more than 665,000 low-income individuals. Through a Medicaid 1115 waiver, Minnesota also operates MinnesotaCare, a sliding scale premium-based health coverage program that serves a monthly average of 140,000 lower-income individuals. Together, these two programs provide coverage for roughly 13 percent of the state's population,[15] making them the state's largest publicly funded health care program.

As of state fiscal year 2011, Minnesota's Medicaid program enrollment was 69.6 percent families and children; 8.4 percent elderly individuals; 17.7 percent disabled individuals; and 4.2 percent adults without children under the state's early expansion.

Minnesota's Medicaid and 1115 waiver program use both fee-for-service (FFS) and managed care delivery and payment structures. Approximately 70 percent of the Medicaid population (560,000 of 800,000 enrollees) is enrolled in managed care and the remaining 30 percent is enrolled in fee-for-service. Minnesota has mandatory managed care enrollment for nondisabled adults and children (state plan) and seniors (under a 1915(b)/(c) combination waiver) and a voluntary opt-out managed care program for disabled adults and children. Managed care is available in all Minnesota counties. Managed care plans in Minnesota are fully at risk for the entire Medicaid benefit set, and paid a per member per month (PMPM) capitation, for all populations. The only exception is that the voluntary managed care program for the disabled does not include personal care assistance (PCA), long-term care, or home and community-based

[15] Minnesota Department of Health – Health Economics Program (2012). Minnesota health care markets chartbook. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html

waiver services as part of the capitation payment to MCOs. Two of the voluntary managed care products available for seniors and people with disabilities are Medicaid/Medicare Advantage integrated products.

3. Population Health Status

A. General health status

In general, the health status of Minnesota is relatively strong when compared to other states. A recent study found that Minnesotans, on average live longer and report healthier adults, healthier children, and fewer unhealthy days than do people nationwide. In fact, 66.9 percent of the population reports being in good or excellent health.[16]

According to the United Health Foundation's 2011 Health Rankings Report,[17] Minnesota is ranked sixth in the United States in terms of overall health, seventh in health determinants, and second in health outcomes. While these are solid rankings, unfortunately, the state's health is declining. In just two years, Minnesota has dropped from second in the country to its current sixth-place position. Some potential reasons for this decline include the fact that, although Minnesota has relatively low mortality due to cardiovascular disease,[18] it is still the second leading cause of death in Minnesota.[19] Also, the same study found that during the years 2006 to 2010, heart disease mortality was 134.7 per 100,000 individuals. The substantial increase in

[16] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN
[17] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN

adult and youth obesity has led to earlier onset of diseases like cardiovascular disease and type II diabetes. In 2010, the diabetes mortality in the state was 19.5 per 100,000 individuals. Chronic conditions (especially heart disease, diabetes, stroke, and arthritis,) and injuries (especially falls) are the major causes of disability and significantly impact quality of life.

Minnesota evaluates its overall population health by monitoring a number of well-tested population-based measures for heart disease mortality, diabetes mortality and level of good/excellent health. These are the same population health measures that Minnesota will rely upon to monitor the Model's impact on statewide population health. Specific population health targets that will be used to measure the State Innovation Plan and the Minnesota Accountable Health Model are described in Section 12, below.

B. Population health issues or barriers that need to be addressed

The innovations under way in Minnesota are serving many of the state's residents. However, there are still significant unmet health and health care needs for the most complex patients across the state, who are also the highest cost patients (if they are in the system) or are not being served at all (which is a different but also substantial cost to the system).

Chronic disease/infectious disease/behavioral risk factors

With regard to the general state population, over the past 10 years the obesity rate in the state has climbed from 17.4 percent to 25.4 percent; there are now more than 1 million obese adults in Minnesota. Over the same period, the diabetes rate has also increased from 4.9 percent to 6.7 percent. Additionally, Minnesota ranks 44th in terms of binge drinking with 18.4 percent of the

population participating and 49th in terms of infectious disease with 23.2 cases per every 100,000 individuals in the state.[20] Further, the fact that Minnesota ranks lower in health determinants than in outcomes suggests that the future health of the state may be in jeopardy.

Mental health

Based on data from the federal Substance Abuse and Mental Health Services Administration, Minnesota has nearly 778,843 adults with mental illness. Using the definition of "serious mental illness" (SMI) as the point at which the experience of the illness significantly impairs life functioning, the rate of SMI in the adult population of Minnesota is estimated at 5.4 percent or 216,073 adults. The prevalence of "serious and persistent mental illness" is estimated at 2.6 percent or 104,035 adults. Significant barriers to mental health services exist in many parts of the state due to provider shortages, especially in rural areas. The lack of coordination between mental health services and somatic health care often results in poor outcomes and higher costs.

Substance abuse

A 2006 study, *Estimating the Need for Treatment for Substance Abuse Among Adults in Minnesota*, estimated that 9 percent of adults in Minnesota met the criteria for substance abuse or dependence that year, but less than one in 10 of those individuals received treatment. In that same year, approximately 18 percent of high school students exhibited a need for treatment but only a little over one in 10 received it. The same study, examining the provision of publically funded treatment services in Minnesota, noted that Minnesota has more unmet substance abuse

[20] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN

treatment needs than more than half of the states in the United States.[21] Many individuals in Minnesota are reluctant to access chemical health services due to the stigma associated with substance use disorders. Public support for the provision of appropriate services to individuals in need is often negatively affected by a perception of addiction as willful misbehavior. This perception persists despite the recognition of chemical dependency as a disease by all of the major medical organizations, including the American Medical Association and the World Health Organization.

Homeless populations

Approximately 13,100 individuals living in Minnesota are homeless on any given night, and 34 percent of this homeless population is under the age of 18.[22] Yet the current health care system so often fails to meet the needs of homeless individuals and individuals with significant mental health and/or chemical dependency issues in addition to somatic care needs. These populations require additional support and resources from the health care system in order to stay healthy. The Minnesota model, which will provide integrated and patient-centered care, will provide the support that these populations need.

Health disparities

[21] McApline, D. D., Beebe, T., McCoy, K., Davern, M. (2006). Estimating the need for treatment for substance abuse among adults in Minnesota: 2004/2005 Minnesota treatments needs assessment survey final report. Retrieved from http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_055443.pdf

[22] Wilder FoundationResearch. Homelessness in Minnesota 2009 (2010). Amherst H. Wilder Foundation. Retrieved from http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota,%202009%20Study/Homelessness%20in%20Minnesota%202009,%20Full%20Report.pdf

As discussed above, Minnesota's minority population is growing. In 2010 populations of color represented 15 percent of the total population in Minnesota.[23] While such cultural diversity can be enriching, it can also present challenges for the health care system. The system often fails to fully recognize and understand the impact that cultural background can have on patient access to and utilization of health care services, knowledge of western medicine, and trust of the health system. Additionally, patients may struggle with language barriers and perceived or real discrimination from the system. Minnesota works aggressively to address these barriers by increasing providers' cultural sensitivities and providing training around offering culturally and linguistically competent care.[24] [25] [26] In addition, Minnesota has provided substantial support to community organizations, local public health agencies, and other groups to develop or implement best practices for reducing health disparities in a variety of areas through its Eliminating Health Disparities Initiative.

Health disparities reflect barriers and inequities on a personal, clinical and health system level. Lack of insurance and lack of primary care clinicians or a Health Care Home are contributing factors to access to health care. Even among individuals with health insurance or access to a health care provider, the disparities in health care delivery also have a profound effect on health

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[23] Martha McMurry (2009). Minnesota population projections by race and Hispanic origin, 2005 to 2035. Minnesota State Demographic Center, Department of Administration. Retrieved from http://www.demography.state.mn.us/documents/MinnesotaPopulationProjectionsbyRaceandHispanicOrigin2005to2035.pdf

[24] Pavlish, C. L., Noor, S., Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Social Science & Medicine*, *71*(2), 353-361. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2893335/

[25] Koppe, S. (2003). Disparities and barriers to utilization among Minnesota health care program enrollees. Minnesota Department of Human Services. Retrieved from http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008306.pdf

[26] Chicano Latino Affairs Council, State of Minnesota (2009). A Latino health report: identifying barriers and solutions to reduced health care disparities. Retrieved from http://www.clac.state.mn.us/issues/CLAC%20Health%20Report.pdf

status and outcomes. Low health literacy, as well as cultural and linguistic competence, plays a critical role in determining the overall health care use.

Although Minnesota has made some gains in reducing health disparities over the past 20 years, the populations of color and American Indians living in the state still experience worse health outcomes. For many health outcomes, populations of color and Americans Indians had a higher burden of chronic disease and associated risk factors, which lead to shorter life spans, higher rates of low-birth weight and infant mortality, higher incidence of diabetes, heart disease, cancer, and other conditions.

One way of looking at health disparities is to calculate a disparity ratio, to see how much higher (or lower) each population of color's rate on a particular indicator is than the population group that has the lowest (or highest) rate. The group with the "best rate" varies by indicator, and it's important to note that for some indicators, such as heart disease mortality, the white population does not have the best rate. Using that approach to compare each Minnesota community of color to the "best" group shows that:

- The rates of homicide, cervical cancer mortality, and new HIV infections were more than 10 times higher among African-Americans than the population groups with the lowest rates.

- The homicide rate for American Indians was eight times higher, the rate of teen pregnancy was more than five times higher, and rates of new HIV infection and diabetes mortality were roughly four times higher than the groups with lowest rate.

- Asians in Minnesota had rates of teen pregnancy, cervical cancer incidence, and homicide that were two to three times higher than the group with the lowest rate.

- For Hispanics, the rates of new HIV infections and teen pregnancy were five to six times higher than the groups with the lowest rates, while rates of cervical cancer incidence and homicide were roughly three times higher.

Rural Disparities

Minnesotans living in rural areas also experienced health disparities compared to other parts of the state. In a report published in 2011, Health Status of Rural Minnesotans[27], the Minnesota Department of Health summarized several key health indicators using data from behavioral surveys and vital statistics records. Several disparities in health behaviors and chronic disease existed between Minnesotans living in rural areas compared to those living in rural areas.

In 2009, 29 percent of men and 28 percent of women living in greater Minnesota were identified as obese, compared to 22 percent of men and 21 percent of women living in the seven county metro region. In Greater Minnesota, 21 percent of men and 16 percent of women reported being current smokers compared to 16 percent of men and 13 percent of women in the seven-county metro region. In Greater Minnesota, 17 percent of men and 20 percent of women reported not exercising in the previous month, compared with only 14 percent of men and 13 percent of women in the seven-county metro region.

[27] Rural Health Advisory Committee (2011). Health status of rural Minnesotans. Office of Rural Health & Primary Care, Minnesota Department of Health. Retrieved from www.health.state.mn.us/divs/orhpc/pubs/workforce/status.pdf

Obesity, smoking and a lack of physical activity can lead to poor health down the road, and rural Minnesotans have poorer health access, and worse health outcomes than Minnesotans living in more urban areas. A higher percentage of people in rural Minnesota were uninsured than in the seven-county metro region, limiting their access to primary care and preventative screening. The more urban southeast and metro regions of the state had lower diabetes mortality rates, at 16 deaths per 100,000 person-years and 19 deaths per 100,000 person-years respectively, when compared with the four more rural regions of the state, which had a range of 21 to 24 deaths per 100,000 person-years. The metro region of the state had a much lower heart disease mortality rate, at 116 deaths per 100,000 person-years, compared to the other regions of the state, which ranged from 146 to 181 deaths per 100,000 person-years.

Health insurance coverage

Trends in coverage are on the wrong track. The uninsured population is growing — up from only 6.1 percent in 2001 to 9.1 percent in 2011. For populations of color the rate of uninsured is even more pronounced. In 2011, 26 percent of the Hispanic/Latino population, 14 percent of American Indians, and nearly 18 percent of African-American Minnesotans were uninsured, compared to 12 percent of Asians and less than 8 percent of the white population.[28] Those with employer-based coverage increasingly bear larger portions of premiums and copays, creating the potential for financial burden and decisions to delay or forego needed care.

Socio-economic status

[28] Minnesota Department of Health (2012). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf

Socioeconomic status and poverty are strongly associated with insurance and health status. State-level 2009 U.S. Census data indicate 10.9 percent of Minnesotans statewide live in poverty. In Minnesota, 33.1 percent of adults whose annual household income is less than $15,000 per year self-rated their health status as "fair or poor" compared to 4.9 percent of adults whose household income was $50,000 or more per year.[29]

4. Health system models

A. Minnesota's current health system model and level of service integration

Minnesota has a long history of integrating care both through the way our providers are organized and by the way our services are coordinated. The Minnesota health care delivery system is predominately comprised of large and mature multi-specialty provider organizations. These large vertically integrated provider systems across the state include hospitals, primary care, specialty care, mental health, and other ancillary services.

In 2008 Minnesota enacted significant state health reform[30] that provided the opportunity to further advance more coordinated and integrated models of care, while increasing transparency about quality and cost of care for providers and consumers. A patient-centered Health Care Home program was enacted that required primary clinics to meet state-specific requirements to become certified and mandated Medicaid (fee-for-service and managed care organizations), the state employees' group, and commercial health plans to make care coordination payments to Health Care Homes (Appendix 9 and Appendix 10). This multi-payer initiative has expanded to

[29] Minnesota Department of Health (2010). Behavioral Risk Factor Surveillance System, 2010.
[30] Laws of Minnesota 2011, Chapter 358

include Medicare with Minnesota's participation in the Medicare Advanced Primary Care Project (MAPCP). Currently, there are nearly 200 certified Health Care Homes in Minnesota, providing coordinated care to nearly two million patients.

Minnesota has long been a leader in providing integrated service models for dually eligible seniors, people with disabilities, and individuals with severe mental illness. Currently, many of the state's Medicaid managed care organizations (MCOs) provide a Medicaid/Medicare integrated program care for approximately 35,000 dual eligible seniors, some through ACO arrangements with their contracted providers that include both acute and long-term care and waiver services to encourage coordination and integration.

While these initiatives have helped to lay the groundwork for further integration of care delivery in the future, they are not always the norm. Throughout the system, we recognize that many redundancies and inefficiencies exist within organizations/systems and between health care and other systems. Many providers (especially small and rural providers) across health care, mental health, chemical health, community health, long-term supports and services, and social services do not currently have the technology or practices necessary to integrate and coordinate care around patients' needs. Exchange of patient information between the medical care system and other supportive services such as behavioral or public health often does not occur, or is still paper-based. These barriers to integration put patients at risk, drive up costs, and generally diminish health in our state.

While we have examples of initiatives in Minnesota that promise to improve integration of care within and beyond health care, many of these initiatives are occurring at a demonstration or pilot

level. Below, we provide examples of some models that are underway in Minnesota and will be built upon and replicated in the future, including via the Minnesota Accountable Health model.

Hennepin Health

Hennepin County, Minnesota's most populous county and home to one of its largest hospitals, Hennepin County Medical Center (HCMC), has committed to transform its payment and care delivery model and embrace ACO payment models and integrated care delivery through the Hennepin Health model. Hennepin Health, an integrated health delivery network financed by a prospective payment for all services provided under the Medicaid program, includes HCMC and other providers as well as the county human services and public health departments and Metropolitan Health Plan, a nonprofit health maintenance organization (HMO) operated by the county. It includes a focus on integration of physical and behavioral health and social services in a patient-centered care model for up to 10,000 individuals per month, with a focus on adults without children in the Medicaid population with incomes at or below 75 percent of the federal poverty level.

Hennepin Health seeks to improve health outcomes and lower the total cost of providing care and services to this population. The project will measure not only direct Medicaid-covered service costs, but also costs beyond the Medical Assistance benefit set, including uncompensated care, human services, and public health costs. The project also will quantify law enforcement, correctional, housing, and court costs and savings, as well as the impact on community agency costs.

The project exists under the state's existing Medicaid managed care authority and brings together core county partners in Minnesota's most populous, urban county to improve outcomes for this

population. Sixty percent of the population participating in the Hennnepin Health project has one of the following characteristics:

- 68 percent minority status
- 45 percent with some level of chemical dependency
- 42 percent with mental health needs
- 30 percent with chronic pain management
- 32 percent with an unstable housing situation
- 30 percent with more than one chronic disease.

The premise of the initiative is that treating a safety net patient's medical problems without addressing underlying social, behavioral, and human services barriers and needs will produce costly, unsatisfactory results, both for the patient and the programs providing and paying for care. Conversely, addressing all of these issues and incorporating them into a coordinated patient-centered, comprehensive care plan should end the cycle of costly crisis care. More information on Hennepin Health is available in Appendix 11.

Integration of Mental Health, Substance Abuse and Social Services

An example of current efforts to integrate physical and mental health is occurring under Minnesota's Medicaid managed care platform. Minnesota has a Preferred Integrated Network (PIN) that joins physical and mental health case management (single point of contact) for adults and children with mental illness or emotional disturbance to improve and coordinate their

physical, mental health, and social services. PIN is a public/private partnership between an MCO (Medica) and a county (Dakota-metro). Interest exists among other MCOs and providers to replicate this model.

The key components of the PIN model include:

- System navigation: A "wellness navigator" for each enrollee to act as a "single source of contact" to help navigate the complex health care system.
- Integrated medical and behavioral health care: Co-located physical health services at mental health drop-in centers.
- Access to care: Access to a full continuum of medical, behavioral, and social service resources and services.
- Shared accountability: An innovative public/private partnership with shared service planning, model development, implementation, gap analysis, and model refinement.

The PIN partners realized that in many cases a traditional care setting would not be the best approach to deliver care, and therefore developed the Clinic Without Walls (CWOW) model, which co-locates physical health care services at mental health drop-in centers.

There is shared accountability between the plan and county as it relates to access to services and resources and service planning with consumers and providers. The partners are committed to joint evaluation, analysis of gaps, and services planning to ensure needs of PIN enrollees are met and are working closely with the Department of Human Services (DHS) on an evaluation of the

program. PINs and the lessons learned could be a model to replicate as a strategy to further integration and affect preponderance of care in Minnesota.

Additionally, the DHS Chemical and Mental Health Services Administration has created the Integrated Dual Disorders Treatment program to ensure that mental health, behavioral health, and addiction services are provided in a fully integrated, comprehensive approach to care. The DHS Alcohol and Drug Abuse Division received a State Prevention Enhancement planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in September 2011 to help the state build on its community-based approach to substance abuse prevention by aligning substance abuse, mental health, primary care, and public health.[31]

Based on recommendations of a large stakeholder input process, the "Mental Health Action Group," Minnesota makes available a significant mental health services benefit set to eligible enrollees in all Minnesota Health Care Programs (not just Medicaid). The benefit set includes not just hospitalization and clinical services, but also targeted case management and community-based rehabilitation services and Assertive Community Treatment. Even with these resources, enrollees often face challenges with coordination of mental health and other health care services.

Health Care Homes

One of the key elements of Minnesota's 2008 Health Care Reform Act was the requirement that MDH establish a process for certifying patient-centered Health Care Homes (HCH), and develop and implement a methodology for providing care coordination payments to certified organizations. Minnesota began certifying HCHs in 2010. In 2011, certified HCHs began

[31] Minnesota Department of Human Services (2012). Minnesota prevention systems alignment plan. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6578-ENG

receiving reimbursement for care coordination through the Medicare program, as part of Minnesota's participation in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration.

Currently there are 190 certified HCHs in Minnesota, with more than 1,800 practicing physicians providing coordinated care to a population of nearly two million patients, 40 percent of Minnesota's population. Roughly a quarter of primary care clinics in Minnesota are certified as HCHs, a number that is increasing at a rate of roughly 20 per quarter. HCHs are distributed throughout Minnesota, though some regions of the state lag others in the rate of certification, possibly due to barriers related to the preponderance of small, independent providers and the lack of penetration of large, integrated care systems in some parts of the state, as seen by Table One below.

Table One: Minnesota Health Care Homes by Region, 2012

Minnesota Region	Total Primary Care Clinics	Total Health Care Homes	Percentage of Clinics Certified	Percentage of Counties with One or More Certified Clinics	Certified Clinics per 100,000 People
Metro	334	110	33%	100%	3.86
NE	62	7	11%	29%	2.15
NW	41	6	15%	29%	3.06
E Central	100	37	37%	63%	4.74
W Central	34	1	3%	14%	0.56
SE	87	16	18%	53%	2.48
SW	76	7	9%	21%	2.13
MN Subtotal	**734**	**184**	**25%**	43%	3.47
Out of State	21	6		N/A	N/A
Total	**755**	**190**			

One of the primary principles of Health Care Homes is the delivery of patient and family centered care. Care that is patient-centered is holistic, recognizing that a person's health is determined by physical, psychosocial, and environmental factors. As part of the recertification process, HCHs are required to identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants.

To assist in that process, the HCH program offers a variety of resources and supports to certified HCHs, including the services of nurse consultants or practice facilitators, training in the establishment of coordinated care teams, care planning and care transition tools, and the opportunity to learn about and deploy innovative models such as the wrap-around care model developed by the Mayo Clinic's coordinated care team. A number of resources have been developed to support HCHs in their care integration efforts through Minnesota's participation in the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration. As part of the Health Care Homes program, three communities (in Ely, Minneapolis and Rochester) have developed Community Care Teams, multi-disciplinary teams that work to integrate care for the whole patient, across medical, long term care, behavioral/mental health, social services, and other settings. These teams will be discussed in more detail in a later section of the Innovation Plan.

Community health/local public health

Minnesota's 53 local public health agencies/community health boards have a long history of working with at-risk populations as well as general populations. All counties in Minnesota have organized public health agencies that are responsible for providing essential public health services. This includes direct services to people with disabilities and elderly individuals to help these individuals remain in the community and to link them to needed services. They support children, pregnant women and families through the Women, Infants and Children (WIC) nutrition program, community-based clinics for child and teen checkups and immunizations, home visiting to parents, infants and children to support optimal child growth and development, and investigation and control of infectious diseases.

Local public health agencies are a key partner of the state and local social service agencies to assess the need for and manage services through home and community-based waiver programs available to individuals who meet eligibility criteria. While public health agencies develop and maintain partnerships with health care providers and hospitals, many areas of Minnesota have a significant gap between local public health and health care services, resulting in inefficiencies and fragmentation between services.

Home and community based services

For individuals with disabilities, long supports and services and are primarily uncoordinated with health care services. This disconnect creates significant barriers to health and quality of life for this population, and presents an opportunity for improvement in the Minnesota Accountable Health Model. During the past decade, a fully integrated managed care product with health care and home and community-based services for individuals with disabilities (MN Disability Health Option) was offered but the care delivery model was financially unsustainable. In our current system, people with disabilities mostly receive care under a fee-for-service model with the option

to opt out of managed care. The available managed care products include some but not the majority of home and community-based services that are needed.

The Minnesota Accountable Health Model is the opportunity for Minnesota to learn from past experiences with managed care for this population. We also have innovative models such as the Courage Center Innovation Award (Appendix 7) that are demonstrating how a home and community-based services organization can effectively integrate health care for people with disabilities and complex health conditions. These lessons learned will be the foundation for moving toward service and payment integration for this population in the Minnesota Accountable Health Model.

Counties and Indian Health

Counties and tribes administer long term services and supports, and lead local community planning such as an analysis of community resources and the needs of those living in their communities in order to identify gaps, and create plans to fill existing gaps in services. At times, they are able to prioritize or repurpose existing dollars to meet identified needs but more opportunities for partnerships with health care and mental health services are needed. Other strategies have included collaborative planning within a region to share resources, securing grants to develop services, accessing resources from other state, tribal or federal agencies (e.g., Housing and Urban Development (HUD) or Minnesota Housing Finance Agency (MHFA)).

Health care services for Indians and tribal members in Minnesota are provided through a combination of tribally-funded and Indian Health Service-funded services (including urban health services). The Bemidji Area of the Indian Health Service is located in Bemidji, Minnesota and provides services and support across four states, including Minnesota's eleven

tribes. There is wide variation across Minnesota in access to and quality of services available to Indians and tribal members, and significant interest among tribes to address existing gaps and eliminate health disparities experienced by American Indians.

In response to the current gaps and issues in health and human services for Indians in Minnesota, there are initiatives underway to enable tribes exercise more autonomy over health and human services, which may entail restructuring of current county services and funding. For example, recent legislation has enabled the White Earth Band to explore options and opportunities for tribal-run human services infrastructure and delivery system.

Area Agencies on Aging *(AAAs)*

AAAs partner with the Minnesota Board on Aging to assist older adults maintain their independent living and manage their multiple chronic conditions. Older Americans Act and state funds allow individuals to access assistance regardless of pay source. The AAAs operate the Senior LinkageLine and provide transitional assistance to people to return home after a hospital or nursing home stay. It is the Aging and Disability Resource Center (ADRC) which, along with the Disability Linkage Line below is a virtual "no wrong door" model. The AAAs through the ADRC are developing partnerships with certified Health Care Homes to integrate community services and primary care for older adults with multiple chronic conditions, with a priority on dementia, regardless of payment. AAAs also have a role through the ElderCare Development Partnerships to build community services available to those at risk. These services are available to those on Medicaid waivers or to "pre-eligible" at risk. The AAAs and the ADRC are an strong resource that could be utilized more effectively as the state moves toward improved integration of services across health care and long term supports and services.

Centers for Independent Living

Centers for Independent Living are consumer-directed organizations supporting people with disabilities to live independently. Two centers, the Metropolitan Center for Independent Living and the Rochester Southeastern Minnesota Center for Independent Living are under contract with DHS to operate the Disability Linkage Line, support Disability Benefits 101, which is an online tool to help people with disabilities understand how employment earning effects their benefits and increase employment outcomes and assist with relocation services to help people move from nursing facilities to their own homes. These resources are often disconnected from health care services for people with disabilities, which creates fragmentation and unnecessary system complexity for individuals and their families.

Service provider organizations

These organizations deliver home and community-based services, and must coordinate their efforts with HCDS to effectively achieve outcomes for the HCDS and health benefits as well as community living outcomes (e.g., employment earnings, living in their own home and deciding who to live with, if anyone, and who will support them, participation in community activities with people who are do not have disabilities, valued reciprocal relationships). Individuals with complex needs often access different services, such as mental health rehabilitation services, and home and community based services through one of Minnesota's five waiver programs. Engagement of the range of providers who are involved with individuals with complex needs is often uncoordinated, which prevents patient-centered services and care.

Community health centers

Minnesota's network of community health centers (also known as Federally Qualified Health Centers or FQHCs) includes nonprofit clinics located in medically underserved areas — both rural and urban — throughout Minnesota. They share a mission of making comprehensive primary care accessible to anyone regardless of ability to pay and focus on improving the health of underserved communities and populations and eliminating health disparities. In addition to primary care, many clinics also provide integrated mental health and oral health services on site.

Minnesota community health centers provided 628,000 visits to 165,000 patients in 2011; 67 percent were racial or ethnic minorities, 41 percent were Medicaid patients, 39 percent were uninsured and 95 percent had incomes below 200 percent of federal poverty level (FPL). These safety net providers lag behind clinics in electronic health record adoption rates in Minnesota and are even farther behind in progress toward achieving meaningful use, struggle to find the resources to become certified Health Care Homes, and face challenges arranging specialty care and hospitalization. They also face barriers following patients and coordinating care for those who are episodic contacts or who move to settings with which the FQHC doesn't have relationships.

School-based clinics

Located in the Twin Cities metro area, 18 school-based clinics provide a comprehensive spectrum of health care services to adolescent students. Through their affiliations with qualified health providers (for example, private medical practices, health care systems, or a public health department), the clinics employ multidisciplinary teams to address adolescent health concerns. Team members include, but are not limited to, nurse practitioners, registered nurses, physician assistants, licensed social workers, physicians, and chemical dependency counselors.

School-based clinics do not require payment for services; the clinics can bill families' health insurance to defray costs. However, in many cases the students who visit the clinics lack health insurance, have large insurance copays, or come in for confidential services that they do not want insurance to cover. Consequently, the clinics rely on public funding, grant money, and, in some cases, contributions from privately run clinics.

School-based health services are supported by a variety of funding streams that make sustainable efforts difficult. To overcome the often fragmented nature of children's services, a close and ongoing partnership between the education, mental health/health care, and public health systems must be maintained and strengthened. The Minnesota Accountable Health Model will support these school systems to collaborate closely so that a local community can then move toward providing a full continuum of prevention-early intervention treatment for children and adolescents.

B. Minnesota's future delivery system model

The future delivery system in Minnesota will focus on the delivery of coordinated, patient-centered primary care, financed by well-aligned, multi-payer, ACO arrangements among commercial and public payers that reward providers for keeping patients healthy. Ultimately, our health system will provide primary care that is fully integrated with behavioral health and long-term supports and services, is supported with community health and prevention resources, and offers consumers meaningful opportunities to choose high-quality, low-cost payers and give input into the care they receive.

The Minnesota Accountable Health Model that will be tested under this proposal will be the core of this new system. The model will help drive the transformation to this more integrated, patient-centered vision. The state's model will build on Medicaid ACO models - Health Care Delivery System (HCDS), which align with ACO models from other public (e.g. Medicare Pioneer ACO and Shared Savings Programs) payers, and the integrated care delivery network of Hennepin Health - and the ACO models of private payers to create financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services. In year two of the model test and beyond, the State will implement and test the Accountable Communities for Health aspect of the Model, which will involve strong support to ACO participants in the HCDS demonstration to develop robust, ongoing partnerships with community organizations and become accountable for the total cost of health of a community through integration of health care, social services, behavioral health, and other aspects of the care continuum.

The Health Care Delivery Systems Model (HCDS)

The HCDS demonstration under the Medicaid program is an accountable care model that supports robust primary care and improves care coordination (e.g., Health Care Homes) for patients by requiring provider organizations to provide the full scope of primary care services and placing a priority on Health Care Homes or similar delivery system reforms and primary care providers for patient attribution. The HCDS model creates financial accountability (through shared savings and phasing in shared risk) for services provided to patients regardless of where they are delivered, equipping participating providers with patient-level data feedback that allows better management of care and the ability to impact care earlier in the care cycle, and ensuring that quality is maintained or improved by requiring performance on a standard set of quality of

patient experience measures be incorporated into the payment model.

HCDS builds off the existing care model and delivery systems of Minnesota's providers, including the state's Health Care Home program, but does not require specific or prescribed care models, allowing flexibility and local solutions for integrating care and coordinating with other provider and community partners. The purpose of the model is to give flexibility to providers to adapt and improve their care delivery models to the specific needs of their Medicaid enrollees and other populations (e.g., further integration of behavioral health into primary care settings) to allow for iterative change and learning best practices.

The HCDS model initially focuses on a core set of health care services that are typically included in commercial ACO contracts — preventive, acute, and certain home care services. To better integrate care for services that fall outside of this core set and reduce the incentive to shift costs to other parts of the system, the state will move providers toward greater accountability for services such as intensive mental/behavioral health treatment models and long-term care services and supports.

As part of the model testing grant, the state will invest in the infrastructure and facilitation of care models that will support providers' ability to accept greater accountability for these services and reduce the barrier to entry of ACO models. This includes supporting providers as they transition to Health Care Homes and CMS' Health Homes (2703) models (see description below) that target populations with specific mental and behavioral health conditions, improved data and information exchange between providers (health care and non-health care), supporting improved care through learning collaboratives and quality improvement initiatives, further development of performance measurement and risk adjustment methodologies and technical assistance to

integrate the use of community supports and services, including better coordination with county case management services.

Community Care Teams and Accountable Communities for Health

Despite Minnesota's leadership in developing innovative models for payment and care delivery, many individuals, particularly those with multiple medical or behavioral health issues, face challenges getting the care they need. Patients with complex conditions often require health care and supportive services (such as mental health or chemical dependency counseling, housing, or rehabilitation services) from multiple entities; for these patients, it is easy to get lost in the cracks. When that happens, appointments are missed, needs aren't met, and quality of life suffers.

On the provider side, the barriers can be equally large. Most health care providers do not partner effectively with available community organizations, are unaware of what services they provide and generally don't understand their work. In many communities there are gaps in community services or community partners are unaware of other service agencies. While electronic health record adoption has advanced in Minnesota, many providers of supportive services such as behavioral health or social services do not have electronic health records, or the means to transmit patient data securely to other partners in the care continuum. There is a lack of integrated case management or coordination in the community that leads to fragmented care and the risk of duplication of care in the community. These gaps in information and data sharing can lead to missed opportunities to improve health.

More globally, we know that up to 70 percent of health is determined by factors outside of the medical system;[32] getting the right care is crucial, but living in the right neighborhood or having the right genetics can be even more so. But most providers do not have the infrastructure — or relationships — in place to allow them to play an active role in influencing the health of their community. Even in ACO models, providers are only held accountable for their patient population, not for improvement in the health of the community in which they operate.

To address these gaps and move towards Minnesota's vision for health care payment/delivery transformation, providers and communities need to move towards accountability for the total cost of health of their populations, and be given tools to equip them to share data effectively across the continuum of services. The foundation for this transformation exists in the Health Care Homes and Community Care Team work already happening in Minnesota.
Community Care Teams are multidisciplinary teams that coordinate care between the health care, behavioral health, and social services sectors so that the needs of the whole person are considered, with a focus on complex patients with multiple comorbidities or service needs. Community Care Teams focus on engaging patients and families, and bringing in partners from education, local public health, youth organizations, and other community resources as needed to create a seamless continuum of support that promotes health and wellness. There are currently three Community Care Team communities in Minnesota, in Ely, Minneapolis and Rochester.

[32] McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, *21*(2), 78-93.

At the heart of the Community Care Team is a Health Care Home: a primary care clinic that provides coordinated, patient-centered care and links patients to needed services. There are currently 190 certified Health Care Homes in Minnesota (roughly 25% of all primary care clinics) (Appendix 2). Health Care Homes receive supplemental care coordination payments through the Medicare and Medicaid programs, as well as from commercial payers.

As we move forward into the new health care delivery system that we envision, we need to learn from and expand these models to create a critical mass of "Accountable Communities for Health" throughout the state: enhanced Community Care Teams that take on financial accountability for population health. An Accountable Community for Health (ACH) can be flexibly structured to meet the needs of communities, but must:

- Include an organization that is participating as an ACO in Medicaid's HCDS program, the Medicare Pioneer ACO/Shared Savings program, or a commercial ACO program;
- Give providers and communities the flexibility to innovate and test new models of care without burdensome new requirements or a one-size-fits-all approach. This includes flexibility in participating providers, setting improvement goals, developing integration models, and conducting local needs assessments.
- Focus on local solutions and move toward inclusion of services beyond health care to create a greater degree of accountability across health care, long term care, public health, mental health, chemical health, oral health, and social services;

- Prioritize care for people with complex conditions and needs;
- Demonstrate significant community responsibility for strategies and priorities;
- Include a plan for the development of a payment model under ACO under total cost of care shared risk/shared savings models with community partners for health improvement activities, and as a step towards financial sustainability;
- Adopt a Health Care Home structure or provide evidence that primary care serves as the center of the care provided;
- Designate an oversight committee made up of a preponderance of citizens/ non health care providers, to be responsible for approving the shared savings structure and use of shared savings, and approving the plan for integration of services; and,
- Develop a community-based public health prevention plan that address the health risks of the community and draws upon available public health resources and leverages funding from other initiatives.

While the initial ACO RFP for the HCDS program signaled the importance of integration of the community into the model, the first nine ACOs participating in that program did not explicitly to include this community component as part of their proposals, possibly due to known or perceived barriers related to effectively partnering in such a way (such as the inability to securely exchange patient data across healthcare, long term care, and behavioral/mental health settings following standard protocols). To accelerate the transition to this new model of care delivery, the State must develop that infrastructure and provide meaningful incentives for change.

Statewide, the transformation of our health system will occur with the engagement of multiple sectors and systems that serve Minnesotans. Below are examples of how several sectors are envisioning and preparing for change within the State Innovation Plan:

Behavioral Health and Substance Abuse Services

For the adult behavioral health system, we will shift the behavioral health service system from an acute care model to a public health and chronic disability management model by emphasizing health promotion, prevention, early intervention, and care coordination at all levels of care. This process will enable us to fill gaps in the current service system both for specialized populations (adults and children with complex needs) and for the general populations (prevention, early intervention, crisis response, recovery supports). The state will implement operational improvements to transform administrative policy-making processes and delivery system operations into efficient, effective, accountable, outcome-driven organizations through the option for Health Homes under Section 2703 of the Affordable Care Act and through the implementation of ACOs and Accountable Communities for Health (ACH).

For children's mental health services, the future model will integrate chemical and mental health care with somatic health care and coordinate both with special education, child welfare, public health, corrections, and county social services — particularly with regard to children and adults with complex or chronic conditions and intensive, high-costs need. In this model, new behavioral health treatments are advanced and proven treatments are utilized because treatment decisions are informed by the latest scientific research. Treatment progress is required before more rehabilitative services are authorized and outcomes are uniformly measured using state-approved instruments. Statewide standards of clinical care would be established and enforced.

Standardized, age-appropriate screening tools would be disseminated and utilized in primary care clinics, child care facilities, child welfare settings, and juvenile justice facilities.

The next step for integration of services for children and for adults is through development of Health Homes. These Health Homes are (behavioral Health Homes) focused on behavioral health as a care management service model that assures that an individual's caregivers communicate with one another so that his or her physical and behavioral health needs are addressed in a comprehensive manner. A care manager will oversee and assure access to all of the services (and coordination with social services and community resources) necessary to stay healthy. Health records will be shared among the providers so that services are not duplicated or neglected. The Health Home services will be provided, using optional models of co-location or in-house or facilitate referral, through a network of organizations that includes providers, health plans, health clinics, and community-based organizations.

Behavioral Health Homes will initially be funded via Section 2703 of the Affordable Care Act, following approval of the state plan that will be submitted before the end of 2012. We expect that the services will include increased care coordination, patient and family support. This justification will be based on a measured decrease cost of services coordinated through behavioral Health Homes (i.e., admissions (physical and behavioral); readmissions; prescription pharmaceuticals, etc.) that would offset the cost of coordination.

An extensive public input and assessment process is under way to shape the outcomes and elements of the behavioral Health Home models. Priority populations are adults with serious and persistent mental illness and co-occurring conditions, and adults with serious mental illness who are not accessing routine and preventative health services. DHS recently received a planning

grant from the CMS to provide resources to aid in the design, public input, and implementation of the Health Home. Efforts will continue to integrate health information using technology to facilitate the Health Home's work and quality improvement efforts.

Community health

The future health system in Minnesota will support policy, system, and environmental changes at the community level to decrease rates of chronic disease and health risk behaviors, and encourage effective partnerships between health care providers and community/public health agencies. Through its Community Transformation Grant (CTG) program, awarded by the Centers for Disease Control and Prevention in 2011, the Minnesota Department of Health's Office of Statewide Health Improvement Initiatives is working to enhance the health of Minnesota communities by supporting healthy choices around eating, physical activity, and tobacco use and by assisting health care providers in their efforts to keep patients healthy. Five CTG grantees whose populations stretch across most of northern Minnesota and include the Leech Lake Tribal Community are currently working to implement community-led health improvement projects that will decrease health disparities, help control health care spending, and create a healthier future.

A key goal of the Community Transformation Grant program is to work with clinics and other providers to improve the delivery of preventive care on four dimensions: 1) measurement of clinical indicators such as body mass index (BMI), blood pressure and cholesterol level control, and tobacco cessation rates; 2) reimbursement of services for lowering blood pressure and cholesterol, BMI and tobacco use; 3) learning opportunities for clinicians on improving healthy eating, physical activity, and tobacco cessation services through referral and follow-up; and 4)

enhanced clinic-community resources for healthy eating, active living, and smoke-free living. As Minnesota moves forward into new health care delivery models, promoting increasing partnerships with community health organizations will continue to be crucial.

Duals Demonstration

The *Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility* demonstration (also known as the duals demonstration) is on the redesign of Minnesota Senior Health Option (MSHO) product. Under that product, DHS contracts with Medicare Advantage Dual Eligible Special Needs Plans to serve dual eligible seniors and provide all Medicare and Medicaid services including primary, acute, long-term care and home and community-based services. The majority of dually eligible seniors are enrolled in MSHO. DHS is continuing to utilize this opportunity to explore with CMS ways in which Medicaid and Medicare can be better integrated for dually eligible people without pursuing the Financial Alignment Model. DHS is focusing on integrated care system partnerships with providers using payment reform models with accountability and metrics for total costs of care.

Minnesota will implement a new purchasing and care delivery model for enrollees who are dually eligible for the Medicaid and Medicare programs. Under the umbrella of the duals demonstration, DHS will implement several service delivery and risk/gain sharing arrangements designed to align with statewide payment and delivery reforms, and to improve accountability for care outcomes across providers and service settings.

In particular, DHS will incorporate purchasing strategies similar to the HCDS models being implemented for other populations to stimulate new “integrated care system partnerships” (ICSPs) between health plans and providers. These partnerships will be designed to integrate

primary care with long-term care and/or mental and chemical health, and will support payment and delivery reforms.

The state will create criteria for the ICSPs including requirements to utilize certified Health Care Homes, primary care payment reforms, integrated care delivery and care coordination across Medicare and Medicaid services, accountability for total costs of care across a range of services including long-term care and/or mental health, shared risk and gain, coordination between primary care and other providers and counties, incentives to provide services in all settings to minimize cost shifting, and enrollee choice of integrated care systems.

DHS is currently in the design, planning, and data collection phase of this project and will be releasing an RFP in 2013.

Home and community-based services

Minnesota has also undertaken a plan for redesign of home and community based services, highlighted in the Reform 2020 request submitted to CMS in July 2012.[33] Reform 2020 recognizes that unnecessary and avoidable costs in health care and high cost long-term care settings, such as nursing facilities or Intermediate Care Facilities for Persons with Developmental Disabilities result without appropriate and stable housing, transportation, community support services for the individual and their caregivers/families, timely transitional services and effective care management. This waiver proposal includes numerous delivery system redesign elements, including:

[33]Minnesota Department of Human Services (2012). Reform 2020 draft Section 1115 Waiver proposal. Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_169839

- Redesigning the personal care assistance benefit to enhance consumer choice and provide maximum flexibility
- Supporting people with a serious mental illness who need short-term, specialized inpatient treatment
- Expanding counseling and transition supports for people who are not yet enrolled in Medicaid but who are considering a move to a nursing home or assisted living
- Enhancing community living supports in order to improve housing stability and consistency of care for people who are homeless and for people who have high medical costs
- Providing employment supports to people who are at a critical transition phase of life to increase income and independence and reduce or delay applications for disability benefits.

Additionally, prevention strategies to increase health of people with disabilities and older adults often are not integrated in the planning, delivery, and evaluation of services by community service providers. To achieve the outcomes of the state innovations that Minnesota envisions those entities responsible for long-term services and supports planning, service development and service delivery must be engaged as part of Community Integration Teams to build capacity in non-health care settings and effectively coordinate in the Minnesota Accountable Health Model that will be tested.

5. Health Information Technology

A. Adoption of Health Information Exchanges (HIE) and meaningful use of electronic health record technologies

Health information technology and health information exchange offer transformative opportunities to improve the health and health care of citizens. Minnesota has been a leader in pursuing bold e-health policies to accelerate the adoption of electronic health records (EHRs) and other health information technology, including the use of statutory mandates and funding to accelerate adoption of EHRs and standards for the exchange of health data. It has also provided a model for effective public-private collaboration to advance e-health goals. As a result, Minnesota health and health care providers are making remarkable progress toward achieving the 2015 Interoperable Electronic Health Records mandate, as established by the Minnesota Legislature in 2008.[34]

Minnesota leads the nation in the adoption of electronic health records and related health information technology (HIT). MDH conducts annual surveys of a variety of health and health care settings to determine the extent of EHR adoption across Minnesota. The health and health care settings surveyed in 2011 had an adoption rate of at least 69 percent for all settings; for hospitals (inpatient, outpatient and emergency department) and clinical laboratories the EHR adoption rate was greater than 90 percent, while ambulatory clinics reported an adoption rate of 72 percent. The majority of ambulatory clinics and hospitals that have not adopted EHRs have plans to do so in the next one to three years, which implies that these practices are on track to meet the requirement for interoperability by 2015.

[34] Laws of Minnesota 2011, Chapter 62L, Section 495

Health information exchange (HIE) makes health information available when and where needed to improve the quality and safety of health and healthcare. Minnesota's approach to health information exchange is based on public good principles to ensure patients will have access to their health information when they need it. Minnesota supports an open market strategy for secure health information exchange that allows for private sector innovation and initiative, and uses government oversight to assure fair practices and compliance with state privacy protections. As a result, many efforts are under way throughout Minnesota to enable the secure electronic exchange of clinical information between organizations using nationally recognized standards.

Currently, most health information exchange in Minnesota takes place between hospitals and clinics in the same system or with affiliated partners. In 2011, 87 percent of hospitals and 64 percent of clinics electronically exchanged health information with one or more partners. However, the rates decrease dramatically for electronic exchange with unaffiliated partners and other providers, which include nursing homes, hospice and home health providers. Just 16 percent of hospitals and 13 percent of ambulatory clinics were exchanging clinical information with non-hospital/non-clinic providers such as nursing homes, assisted living, or home health providers in 2011. Just 35 percent of clinics and 49 percent of hospitals were exchanging Continuity of Care Records (CCR) electronically.[35]

E-prescribing is the bidirectional electronic information exchange between prescribing providers, pharmacists and pharmacies, and payers or pharmacy benefit managers (PBMs). E-prescribing has the potential to dramatically reduce medication errors, as well as lowering transactional costs related to prescriptions. An important element in improving the quality of patient care, e-

[35] Minnesota Department of Health. Minnesota e-Health Assessment Reports, Factsheets and Briefs. Retrieved from http://www.health.state.mn.us/e-health/assessment.html

prescribing in Minnesota has made significant progress since December 2008 when only 57 percent of pharmacies were e-prescribing. As of October 2011, 90 percent of pharmacies were e-prescribing with more than 13.5 million e-prescribing transactions occurring during the first 11 months of 2011, a 40 percent increase from the previous year. In July 2012, Minnesota was named the No. 1 e-prescribing state in the nation by SureScripts in its annual SafeRx awards, with the highest rate of e-prescribing by physicians, pharmacies and payers.[36]

B. Strategies and approaches to improve use and deployment of HIT.

While much of the foundation has been laid through the efforts of the Minnesota e-Health Initiative, a public/private collaborative led by MDH, considerable work remains to ensure that all providers and all Minnesotans can share in the benefits of e-health. The State e-Health Alliance has noted that *"…the high costs, avoidable deaths, poor quality, and inefficiency of the current system drive urgency for transformation. But … if not smartly coordinated, it may only result in an electronic version of the 'siloed,' inefficient system we have today."*

Ensuring the smart and coordinated implementation of health information technology and health information exchange to improve the health of Minnesotans will continue to be the vision and focus of the Minnesota e-Health Initiative and the Minnesota Department of Health. Although there are high EHR adoption rates in Minnesota, the real value from investing in and implementing an EHR, and other HIT, comes from using it effectively.

Effective use is about utilizing the full potential of the EHR to achieve the core values of increased patient safety and improved quality of care that accrues to the organization, the patients and the community. Indicators of effective use of EHRs available for clinics, hospitals,

[36] Minnesota Department of Health. Minnesota e-Health Assessment Reports, Factsheets and Briefs. Retrieved from http://www.health.state.mn.us/e-health/assessment.html

nursing homes and pharmacies include the use of clinical decision support, e-prescribing and computerized provider order entry (CPOE) of medications, use of medical guidelines, reminders or alerts for preventive care, and tools to monitor and improve the health of high-risk populations. Minnesota providers' performance on these and other measures are described later in this document, and in Minnesota's Project Narrative.

In the coming years, Minnesota plans to explore or implement the following strategies to increase EHR and other HIT adoption and meaningful use, and the secure, standards-based exchange of clinical health information, with a strong focus on preparing providers for a future care system in which care is integrated across provider types and coordinated care is the norm:

- Assessing progress on adoption and use of EHRs, identifying gaps and barriers to success, and developing pragmatic guidance and resources for organizations to address them

- Implementing a federal State Health Information Exchange Cooperative Agreement to establish a framework to enable health information exchange to improve continuity and coordination of care, including establishment of statewide shared services for HIE

- Promoting widespread adoption and use of privacy and security standards based on national recommendations and Minnesota law

- Evaluating the impact the adoption of these technologies have on health care quality, patient safety, cost efficiencies, and public health

- Identifying and disseminating best practices, practical guidance and resources for organizations to fully realize the potential of these tools

- Engaging patients and consumers to take an active role in their health and health care, with a clear understanding of how e-health tools can assist them in achieving their health goals

- Continuing to invest in Minnesota's EHR grants and loan programs to assist small health care providers to achieve interoperable electronic health records across the continuum of care, meet federal meaningful use requirements, and recoup investments through Medicare-Medicaid meaningful use incentive payments.

Additionally, the state plans to devote additional resources for EHR adoption to settings that have not been eligible for federal incentives, including public health, social services, and behavioral health/mental health providers. There is a high need to support exchange of clinical information across these settings to aid in care coordination, and few resources have been available for HIT adoption or exchange. Pursuing this strategy will require significant resources for grants to support EHR adoption, technical assistance, and collaborative activities with providers.

6. Delivery System Payment Methods

A. Current delivery system payment methods

The Minnesota Department of Human Services helps people meet their basic needs so they can live in dignity and achieve their highest potential. Roughly 800,000 Minnesotans on average received health care coverage through the state's publicly funded basic health care programs in state fiscal year 2011: Medical Assistance (MA — Minnesota's Medicaid) and MinnesotaCare (a Medicaid expansion program that operates through an 1115 waiver). Through these programs, the state pays for all or part of enrollees' medical services. About 74 percent of DHS' all-funds

(state and federal funds) budget was devoted to these programs in FY 2011. About half of enrollees in all programs combined were children under 21.[37]

Minnesota's Medicaid program has both fee-for-service and managed care delivery and payment structures. Approximately 70 percent of our Medicaid population (560,000 of 800,000 enrollees) is enrolled in managed care, with the remainder in fee-for-service. Minnesota requires mandatory managed care enrollment for nondisabled adults and children (state plan) and seniors (under a 1915(b)/(c) combination waiver) and provides a voluntary opt-out managed care program for disabled adults and children. Managed care is available in all Minnesota counties. Managed care plans in Minnesota are fully at risk for the entire Medicaid benefit set, and are paid a PMPM capitation, for all populations, except that the voluntary managed care program for the disabled does not include personal care assistance (PCA), long-term care, or home and community-based waiver services as part of the capitation payment to MCOs. Two of the voluntary managed care products available for seniors and the disabled are Medicaid/Medicare Advantage integrated products.

Regarding payment reform activities in the commercial market, the state surveyed Minnesota health plans during the summer of 2012 regarding the extent of their current ACO contracting activity. This information, coupled with publicly available information,[38] revealed that:

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[37] Minnesota Department of Human Services (2012). Minnesota Health Care Programs. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4932-ENG

[38] Bailit, M. H., Hughes, C., Burns, M., and Freedman, D. H. (2012). Shared savings payment arrangements in health care: six case studies. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1624_Bailit_shared_savings_payment_arrangements_six_case_studies.pdf

- Within the commercial market, health plans report between one-third and two-thirds of covered lives or spending associated with ACO contracts, with higher percentages in the Twin Cities region than elsewhere in the state.

- Within the Medicare Advantage and Medicaid markets, health plans also report use of ACO contracts. Prevalence for Medicare Advantage and Medicaid appears to be highly variable across plans, and perhaps generally lower for Medicaid than for commercial business.

- Most ACO contracting arrangements appear to be "upside only" for provider organizations, although there are mixed upside/downside arrangements.

Health Care Homes

As part of Minnesota's 2008 health reform legislation, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) were required to develop a system of per-person care coordination payments to certified Health Care Homes.[39] This payment methodology applies directly to the Minnesota Health Care Programs (MHCP). Other affected payers (including the State Employee Group Insurance Program and state-regulated private health plans) are required to implement a payment system "in a manner that is consistent with" the public programs. DHS and MDH consulted extensively with a variety of health care stakeholders throughout 2009 to develop the payment methodology, and the HCH payment methodology was implemented on July 1, 2010. This payment methodology currently applies to

[39] The statutory language and rule that established the Health Care Homes program can be found in Appendix 2.

190 certified Health Care Homes, representing roughly one-quarter of all primary clinics in the state. Applications are pending from additional primary care clinics.

The payment methodology categorizes patients into "complexity tiers" based on the number of major chronic condition groups (such as cardiovascular, respiratory, and endocrine) identified by the provider treating them in the HCH. Providers identify patients and assign a tier level for payment based on common requirements, and payers can audit the basis for tier assignment and the work associated. If the patient has a language barrier or a serious mental illness, these supplemental factors each garner a defined-percentage increase in the payment rate associated with each tier. The HCH practice must develop a process to determine which patients are eligible for payment and at which tier level. The HCHs then submit a claim using a set of defined procedure codes and modifiers linked to the patient's tier level. Billing occurs on a monthly basis, and the patient's complexity level should be reassessed annually at a minimum.

Through Minnesota's participation in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration, as of Oct. 1, 2011, certified Health Care Homes are being reimbursed for care coordination services provided to fee-for-service Medicare beneficiaries. CMS uses Minnesota's HCH payment methodology for care coordination reimbursement.

Current payment models in the commercial sector

Payment innovation in Minnesota extends far beyond public sector initiatives. Minnesota's health plans and providers are at the national forefront of payment reform. Within the commercial market, health plans report having between one-third and two-thirds of their covered lives or spending associated with ACO contracts, with higher percentages in the Twin Cities region than elsewhere in the state. Within the Medicare Advantage and Medicaid markets, health

plans also report use of ACO contracts. Prevalence for Medicare Advantage and Medicaid appears to be highly variable across plans, and generally may currently be lower for Medicaid than for commercial business.[40] In addition, three Minnesota providers were selected as Pioneer ACOs (Allina Hospitals and Clinics, Fairview Health Systems, and Park Nicollet Health Services) and Essentia Health is participating in the Medicare Shared Savings program.

Many of these commercial and Medicare Advantage TCOC arrangements involve "upside only" risk assumption by the provider organization. Outside of these initiatives, payment remains fee-for-service based. There has been very little use of bundled payments within the state. In addition, payment arrangements for certain services remains primarily fee-for-service.

The level of commitment to payment innovation currently present in the Minnesota marketplace positions the state well for success in its transformation efforts.

B. Future delivery system payment methods.

As noted above, Minnesota has long been a national leader in developing innovative and effective payment and care delivery models such as Health Care Homes and integrated Medicare and Medicaid managed care programs. These reforms have been premised on the idea that incentives in the health care payment system need to be adjusted and aligned to promote better outcomes and lower costs. Yet, we are aware that additional transformation is necessary for us to achieve our goals.

[40] Minnesota Department of Human Services (2012, July). Survey of health plans.

Our aim is to build upon existing initiatives and advance payment reform toward ACO contracting across public and private payer programs, and across the array of providers who support the health of the publicly and privately covered populations. Given the high level of adoption of ACO contracting already in place, the state believes that the majority of health care services and long-term care services will be delivered under ACO contracts by the end of the State Innovation Model testing period. The state will also strive for a "future to be" payment system with the following characteristics:

- Providers face aligned performance incentives using common performance measures appropriate to the covered population.
- Providers have access to necessary information to manage their patient populations, including those most at risk, in the most effective method possible.
- Providers serving state public programs beneficiaries realize integration opportunities across health care, mental health, long-term care, and social services.
- Providers assume "downside" risk when it is financially appropriate for them to do so to provide the necessary motivation for transformation and waste reduction.
- ACO-contracting entities have incentives that are aligned with those of Accountable Communities for Health.

Minnesota Medicaid's ACO Payment Demonstration – Health Care Delivery Systems (HCDS)

Overview and goals

State legislation enacted in 2010 gave DHS authority and flexibility to implement gain- and risk-sharing payment models directly with providers. The statutory language that authorized the HCDS program is included in Appendix 12. The state began the demonstration design and development process with broad community input through a Request for Information (RFI) and a series of stakeholder meetings. The state received 40 responses from provider systems, health plans, counties, nonprofits and other community organizations. The complete list of organizations that responded to the RFI is included in Appendix 13.

Based on the RFI responses the state received, and emerging national and local models of alternate payments such as gain/risk-sharing, health care homes, ACO, the state developed a three-year demonstration called Health Care Delivery Systems (HCDS) to contract directly with providers for the total cost of care for Medicaid enrollees. The HCDS' ACO model is based on the following principles and key design features:

- Allow providers flexibility to provide innovative methods for coordinating and delivering care (leveraging the work already under way by the early innovators) that improve patient health and experience and reduce costs with few new requirements (i.e., no new legal entity required, must provide primary care, must have formal community partnerships, do not administer benefits or pay claims). The state is focusing on accountable payment models instead of defining the ACO entity.

- Develop models for both large integrated systems and smaller or independent providers to ensure broadest participation possible.

- Build off current payment and care delivery reform efforts and structures — such as Health Care Homes — work within existing fee-for-service (FFS) and managed care structures to allow faster implementation timelines and minimize enrollee disruption.

- Focus on building up basic elements to make the demonstration successful, e.g., providing actionable data feedback from a combined FFS and managed care data stream; moving providers to risk-based payment and providing actuarial expertise.

- Alignment with payment models in the Minnesota commercial market and other emerging national models (Medicare Shared Savings, Pioneer ACO) to drive delivery system transformation, but also consistent Medicaid payment (MCO and FFS) at the provider system level.

Nine (9) responses received, broadly representative of geographic and organizational structure. Eight (8) systems applied under Integrated Model and one (1) under the Virtual Model

System Requirements

The state developed the requirements for HCDS with the goal of leveraging the innovative care delivery reforms of Minnesota's providers and not requiring providers to form new legal entities or significant new burdens that may become a barrier to participation. The state also wanted to ensure the requirements did not limit the ability of small or rural providers to apply for the model. The HCDS requirements include:

- Deliver the full scope of primary care services and directly deliver or demonstrate the ability to coordinate with specialty providers and hospitals.

- Demonstrate, through the care delivery model, how the HCDS ACO model will affect the total cost of care of its MHCP participants regardless of whether the services are delivered by the HCDS.

- Demonstrate how formal and informal partnerships with community organizations, social service agencies, counties, etc., are included in the care delivery model. Responders are encouraged to propose mechanisms to incorporate these organizations directly into the payment model.

- Demonstrate how the HCDS ACO will meaningfully engage patients and families as partners in the care they receive, as well as in organizational quality improvement activities and leadership roles.

Payment Approaches

The state will test two payment approaches under the HCDS ACO demonstration that will hold providers accountable for the total cost of care (TCOC) for Medicaid enrollees attributed to them based on historical claims (across managed care and FFS, common risk pool) for a core set of services.

The state will calculate TCOC target and observed HCDS ACO performance against the target for defined set of core services included in TCOC, HCDS ACO may elect to include additional services. Core services primarily include preventive, acute, and home care services. Existing provider reimbursements persist (FFS and MCO) during the performance period. HCDS performance on quality and patient experience measures impact a percentage of the payment, which increase over the three years of the demonstration.

Virtual model for providers not part of an integrated system, i.e., are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems, or with an attributed population size between 1,000 and 2,000.

- Years 1 to 3: Gain-sharing only, shared savings is 50/50.
- Providers not in an integrated system with a hospital have less ability to assume downside risk, but are still accountable for the same set of services.

Integrated model for providers that are part of integrated system that provide a broad spectrum of outpatient and inpatient care as a common organizational and financial entity.

- Year 1 – gain-sharing only (same as virtual).
- Year 2 – introduce downside risk. Flexibility in the amount of risk an HCDS can assume but upside cannot be more than twice the downside.
- Year 3 – symmetrical risk. HCDS still have flexibility in the amount of risk (percentage against the target and shared with the state)

Phase-in of downside risk The state chose to phase in downside risk for providers in years 2 and 3 of the demonstration; providers have flexibility in how much risk they will assume.

- Moves providers toward a prospective, risk-based payment (similar to Medicare models). This is where most Minnesota providers directionally want to go. This allows for investment, more easily move resources to where they are needed.

- Large integrated systems in Minnesota have the financial wherewithal to assume some level of downside risk. The decision was made not to phase-in downside risk for smaller providers and non-integrated clinic system in the initial implementation of the demonstration due to investment needed in care models and technology.

- Provides the right incentive to make major changes and savings to the state.

7. Health care delivery system performance

A. Current health care delivery system performance measures

Minnesota has a long history of making investments in bringing data and evidence to quality improvement. This has positioned the state in a place where transparency on provider quality has become a shared goal of private and public stakeholders, where measure development in many areas leads the nation, and where reporting aims to evolve toward more actionable measures of quality, including patient-reported measures and measures of functional status.

As a result of passage of the 2008 Minnesota Health Reform Law, Minnesota is implementing the Statewide Quality Reporting and Measurement System (SQRMS), a uniform system for reporting data on quality performance by hospitals, physician clinics, and ambulatory surgery centers. Currently, the system comprises 18 physician clinic measures, 95 hospital measures, and three ambulatory surgery center measures. A selection of the SQRMS measures and statewide rates is included in Table Two, below. The complete list of measures that are collected through SQRMS can be found in Appendix 14.

In addition to monitoring performance on a wide range of quality measures for providers and payers, Minnesota also invests considerable resources in monitoring the adoption of

electronic health records and the use and secure exchange of health information. The MDH Office of Health Information Technology conducts an annual assessment of EHR adoption, use of clinical decision support, rates of e-prescribing and computerized provider order entry (CPOE), and exchange of clinical information both within systems/networks and with providers outside of a system or network. The annual assessment covers hospitals, clinics, local public health agencies, nursing homes, pharmacies, and clinical laboratories.

Data from the most recent ehealth assessment, conducted in 2011, showed dramatic progress on many of these measures over the last few years, but also significant gaps that still need to be addressed, particularly in the area of health information exchange. These gaps serve as a substantial barrier to clinical integration and care coordination, as well as to quality improvement.

Table Two: Key Measures Collected through the Statewide Quality Reporting and Measurement System (SQRMS) and by the MN Office of Health Information Technology

Quality Measure	**2010 rate (statewide)**	**Range**
Optimal care for heart attack patients	97%	88-100%
Optimal care for heart failure patients	83%	26-98%
Optimal care for adults with high blood pressure	70%	34-85%
Optimal care for pneumonia patients	85%	33-100%
Optimal care for adults with diabetes	28%	0-57%
Optimal care for adults with vascular disease	34%	0-63%

Optimal care for children with strep throat	86%	27-99%
Central Line infection prevention bundle	87%	0-100%
Mammogram in past two years for women ages 52-69	83%	55-91%
Pap smear in the past three years for women ages 24-64	80%	50-89%
Adults ages 51-80 who received colorectal cancer screening	72%	43-94%

Health Information Technology Measures	**2011 Rate**
Clinics with an electronic health record	72%
Hospitals with an electronic health record	93%
Nursing homes with an electronic health record	69%
Chiropractic offices with an electronic health record	25%
Pharmacies actively e-prescribing	93%
Clinics routinely using preventive care reminders/alerts in EHR	54%
Hospitals using clinical reminders/alerts	41%
Nursing homes routinely using preventive care reminders/alerts in EHR	47%
Clinics able to submit information from EHR to immunization registry	51%
Hospitals able to submit information from EHR to immunization registry	54%
Clinics exchanging health information outside system/network	41%
Clinics exchanging health information with non-hospital/clinic providers	13%
Hospitals exchanging health information outside system/network	43%
Hospitals exchanging health information with non-hospital/clinic providers	16%
Local health departments exchanging health information with MDH	44%
Nursing homes with capability to exchange health information	38%

On many quality measures, rates for Medicaid enrollees lagged behind those for enrollees in commercial plans. For example, rates of optimal diabetes care for Medicaid enrollees were twelve points lower than for other purchasers, and rates for optimal vascular care were thirteen points lower for the Medicaid population. The gap was just as wide for many preventive screening measures such as breast cancer screening (13%), and colorectal cancer screening (19%).

Table Three: Medicaid/CHIP Quality Measures and Disparities with other Payers

Measure	**2011 Disparity (Medicaid vs other payers**
Optimal care for adults with diabetes	12%
Optimal care for adults with vascular disease	13.2%
Optimal care for children with strep throat	5%
Pap smear in the past three years for women ages 24-64	6.5%
Mammogram in past two years for women ages 52-69	13.3%
Adults ages 51-80 who received colorectal cancer screening	19.2%

B. Future health care delivery system performance measures

The Minnesota Model is designed to address the drivers of low quality or variable quality care. One of the current barriers to improved service integration and patient outcomes is the lack of data analytic capacity among some providers. The Minnesota Model Testing will address these barriers through better data reporting and feedback to providers, support via statewide and regional quality improvement initiatives and learning collaboratives, and resources to develop the capacity for real-time data analytics and quality improvement through HIT-enabled quality reporting at the provider level.

To supplement the SQRMS measures on which Minnesota already collects data, the State will also continue developing new measures in a number of areas. These new measures will be used to monitor impact of the model on care delivery and patient outcomes. The state will also work with Accountable Communities for Health to establish measures that are appropriate to the priorities and activities of their work, including measures of care integration.

Measures of patient experience: will be a cornerstone of the future performance measurement system. Such measures aim to understand whether and how delivery system reform improves indicators such as patient satisfaction, confidence in receiving care when needed, experience with discrimination in the health care system, and measures of outcome and functional status. Data is currently being collected for the first time on a patient experience measure as part of SQRMS, and other measures may be added during Phase Two of this proposal.

With regard to measures of provider quality related to outcome, functional status, and patient reported indicators of health, the state will continue to do more work in this area as part of the evolving Statewide Quality Reporting and Measurement System. This work will continue to be based on community and stakeholder input, rigorous testing and scientific evidence, and may expand to include additional measures related to transitions of care and all-cause readmission. Measures may include indicators such as all-cause hospital readmission, preventable emergency department visits, and self-reported health status indicators such as number of healthy days or days with limitations of activity due to physical problems. Measures may also include metrics that are targeted at medically complex patients, children, or other special populations.

Measures related to reducing per-capita cost rely on improving the existing data structure and timeliness of cost data. Current measurement initiatives rely on aggregated statewide data or private sector activities related to ACO contracts in the commercial market.

As the Accountable Communities for Health model expands into new communities, Minnesota will need to develop and test new approaches for measuring care integration and community engagement, as well as operationalizing measures related to coordination of care that are currently under development. The ACH aspect of the Minnesota Model offers unique

opportunities to develop and test locally relevant measures that are developed with significant community and consumer input.

8. Current health care cost performance trends

A. Current trends

MDH uses data from health care purchasers to estimate annual health care spending trends in the state. This includes analysis of year-over-year growth, trends for public and private purchasers, and drivers of health care cost growth. As part of this analysis, MDH compares actual growth to projected growth to estimate the effect of Minnesota 2008 reforms on health care spending trends.[41] [42]

For the analysis of drivers in the private market, MDH analyzes data from health plans in the state to monitor premium and expenditure growth in the private market and identify how much the health plan enrollee share of costs have risen compared to that for health plans. Summary findings from the most recent report include[43]:

- Health care spending in Minnesota reached $37.7 billion, accounting for 13.9 percent of the state's economy.

[41] Health Economics Program, Minnesota Department of Health (2011, March). Health insurance premiums and cost drivers in Minnesota. *Issue Brief*. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/costdrivers2011.pdf

[42] Health Economics Program, Minnesota Department of Health (2012, July) Minnesota health care spending and projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

[43] Health Economics Program, Minnesota Department of Health (2012, July) Minnesota health care spending and projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

- Health care spending grew just 2.2 percent from 2009. Private spending remained nearly constant, increasing by 0.3 percent and public spending grew at a slow pace of 4.7 percent.

- Minnesota's Medicaid program accounted for 19.4 percent of total spending.

- Per capita spending in Minnesota reached $7,090, well below the national per capita spending estimate.

- Health care spending in Minnesota is expected to more than double over the next decade in the absence of reforms to curb spending growth, including those passed in 2008.

- Estimated actual spending excluding Medicare and long-term care in 2010 was $20.6 million above the projection.

- In 2009, as Minnesota's economy contracted and incomes of Minnesota residents on average decreased by 3.2 percent, health care costs rose 5.9 percent and premiums increased by about 7 percent.

- Total spending per enrollee (health plan spending plus enrollee out-of-pocket cost) increased by 6.2 percent in 2009, up from 5.1 percent in 2008.

- Continuing historical trends, enrollee out-of-pocket costs grew faster in 2009 than health plan spending (7.4 percent compared to 5.9 percent).

- In aggregate, enrollee cost sharing accounted for 15.9 percent of total private spending in 2009, up from less than 10 percent just a decade ago.

- As in previous years, the primary drivers of health plan spending growth were physician and hospital services (both inpatient and outpatient), which together accounted for more than two-thirds of health plan spending growth between 2007 and 2009.

- Per member per months spending for Medicaid has been at an average annual 4 percent over the past 10 years, reflecting low and declining PMPM growth between 2001 and 2008. PMPM growth rose to double digits in 2010 and 2011 (11.7 percent and 14.9 percent, respectively).

In contrast to Medicaid, MinnesotaCare, the sliding fee scale program for low and middle-income Minnesotans, saw significant growth in PMPM spending over the past 10 years (9.7 percent average annual growth over 10 years). 2011 growth in PMPM spending declined by 1.4 percent, following two years of double digit increases. Enrollment in both programs has been growing at near double-digits in Medicaid in 2010 and 2011 and above double-digits (12 percent per year) for MinnesotaCare for both years. Growth has in both programs has been affected by the recession and slow economic recovery, as well as Minnesota's decision to accelerate Medicaid expansion for individuals with incomes up to 75 percent in early 2011.

At the payer level overall, there is much ongoing effort in support of the development of ACO contracts, both in the private market, for public payers and for the State Employee Group Insurance Program, the insurance arrangement for the state's workforce. At this point, there is not much transparency in the methods used and the performance outcomes. However, efforts are under way both as a private market initiative and as a publicly directed effort to align current methods and develop cost data for public reporting.

B. Factors affecting cost trends

The majority of health care spending came from private funds in 2010 (55.4 percent), with private health insurance providing the largest share (40.5 percent of total spending). Patients contributed more than 12 percent of total spending out of pocket. The remaining 2.5 percent of private spending came from other sources. Public sources comprised the other 44.6 percent of total spending in 2010, with Medical Assistance, Minnesota's Medicaid program, accounting for 19.4 percent. Medicare accounted for 18.3 percent of public spending. Other sources of public funding made up the remaining 6.9 percent. The share of public spending for health has been increasing in relation to private spending for a number of years both in Minnesota and the United States.[44]

Minnesota does not have data available to analyze drivers of health care cost growth. Abstracting from national research, one of the biggest drivers of health care cost growth is technology,[45] encompassing factors that result in treatment substitution – providing health care in new and different ways — or treatment expansion — being able to treat care needs because of new scientific and technological developments. At a national level, prices and income growth appear to be the next highest drivers of growth, accounting for between 20 percent and 40 percent of health care cost growth. Research shows consistently that at this point, factors associated with population changes, administrative expenses, and changes in third-party payments play a less significant role in explaining health care cost growth.

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[44] Health Economics Program, Minnesota Department of Health (2012, July) Minnesota health care spending and projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

[45] Ginsburg, P. B. (2008). High and rising health care costs: demystifying U.S. health care spending. Robert Wood Johnson Research Synthesis Report No. 16.

There are other factors at a more granular level affecting cost trends that are not well understood and detailed in existing research. These include, among others, the growing trend in obesity;[46] the inadequate focus of primary care and prevention; the lack of connectivity between medical care, social services and public health; the lack in the coordination of care, particularly for patients with complex needs; as well as the limited extent to which care is patient centered. It is these factors that Minnesota is trying to affect with its proposal to transform the delivery system through changes in payment signals, infrastructure investments, the provision of technical assistance, and an offer of a range of tools available to different test sites.

[46] In 2011 more than one quarter of Minnesota adults were obese, up from less than 14 percent in 1991. Centers for Disease Control, 2012.

Table Four: Minnesota and U.S. Shares of Health Care Spending by Payer

Minnesota and U.S. Shares of Health Care Spending by Payer

	2006	2007	2008	2009	2010
Shares of Minnesota Health Care Spending by Payer					
Public Spending, Total	40.5%	41.2%	42.2%	43.6%	44.6%
Medicare	17.1%	17.0%	17.4%	17.8%	18.3%
Medical Assistance	17.4%	18.1%	18.5%	19.0%	19.4%
Other Public Spending /1	6.1%	6.1%	6.3%	6.8%	6.9%
Private Spending, Total	59.5%	58.8%	57.8%	56.4%	55.4%
Private Health Insurance	43.0%	42.5%	41.9%	41.0%	40.5%
Out-of-Pocket	13.7%	13.6%	13.2%	12.8%	12.3%
Other Private /2	2.7%	2.7%	2.6%	2.6%	2.5%
	2006	**2007**	**2008**	**2009**	**2010**
Shares of U.S. Health Care Spending by Payer/3					
Public Spending, Total	46.1%	46.4%	47.2%	48.4%	49.2%
Medicare	19.8%	20.1%	20.8%	21.3%	21.5%
Medicaid	15.8%	15.9%	16.1%	16.7%	17.2%
Other Public Spending /1	10.5%	10.4%	10.4%	10.4%	10.5%
Private Spending, Total	53.9%	53.6%	52.8%	51.6%	50.8%
Private Health Insurance	36.4%	36.0%	35.9%	35.3%	34.7%
Out-of-Pocket	13.4%	13.3%	13.1%	12.5%	12.3%
Other Private /2	4.0%	4.2%	3.8%	3.8%	3.8%

Source: MDH Health Economics Program, Centers for Medicare & Medicaid Services
/1 Major components of other public spending are MinnesotaCare, General Assistance Medical Care, government workers' compensation and Veterans Administration
/2 Other major private payers include private workers' compensation and auto medical insurance
/3 U.S. comparison - CMS National Health Expenditure Accounts, Health Consumption Expenditures . This does not include research and investment

Table Five: Minnesota's Spending for State Administered Programs as a Percent of Total Spending, 2010

Spending for State Administered Programs as a Percent of Total Spending, 2010

	Actual Spending (Billions)	Percent
Total Spending /1	**$25.8**	
Spending Not State Administered	**$20.4**	**79.0%**
Total State Administered Programs /2	**$5.4**	**21.0%**
Medical Assistance	$3.9	15.1%
MinnesotaCare	$0.7	2.8%
General Assistance Medical Care	$0.2	0.7%
State Employee Group Insurance Program	$0.6	2.3%

Source: MDH Health Economics Program
/1 Excludes spending for Medicare and long term care
/2 Excludes spending for long term care

Spending projections

As a share of the economy, health care spending is anticipated to grow to 17.9 percent in 2020 in Minnesota, without reform[47]. That would mean that one out of every six dollars of economic activity would be devoted to health care. In recent years, we have observed faster growth in public health care spending than private spending and a narrowing of the gap between public and private spending in the actual health spending estimates in Minnesota. The projection model predicts this trend to reverse somewhat over the next decade with average annual private spending growth outpacing average annual public spending. By 2020, private spending is estimated to account for 61.0 percent of total spending and public spending for the remaining 39.0 percent. This does not include effects of state or federal health reform.

[47] Health Economics Program, Minnesota Department of Health (2012, July) Minnesota health care spending and projections, 2010. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf

9. Current quality performance

Marketwide, the Statewide Quality Reporting and Measurement System (SQRMS) data shows that hospital and clinic performance on many SQRMS measures was high — as high as 97 percent for "optimal care for heart attack patients." However, performance on measures related to optimal care for diabetes and vascular disease, rates were well below 50 percent. For many measures, performance ranged broadly, suggesting that many hospitals and clinics could benefit from assistance in replicating the successes of their colleagues.

Table Six: Minnesota's Statewide Hospital and Clinic Performance on Key Quality Performance Indicators

Measure	**2010 rate (statewide)**	**Range**
Optimal care for heart attack patients	97%	88-100%
Optimal care for heart failure patients	83%	26-98%
Optimal care for adults with high blood pressure	70%	34-85%
Optimal care for pneumonia patients	85%	33-100%
Optimal care for adults with diabetes	28%	0-57%
Optimal care for adults with vascular disease	34%	0-63%
Optimal care for children with strep throat	86%	27-99%

Central Line infection prevention bundle	87%	0-100%
Mammogram in past two years for women ages 52-69	83%	55-91%
Pap smear in the past three years for women ages 24-64	80%	50-89%
Adults ages 51-80 who received colorectal cancer screening	72%	43-94%

Generally speaking, data show that there are differences across payers that are consistent across multiple clinical areas. For example, the overall rate of patients who received optimal diabetes in physician clinics was 28 percent in 2010. But just 27 percent of diabetics who were enrolled in Medicaid received optimal diabetes care, compared with 39 percent of those enrolled in commercial plans or Medicare. Similar variations exist for other measures, generally indicating lower rates of quality of services to the Medicaid population. For example, in 2010, the evidence shows that this population receives recommended care at significantly lower rates for:

- Optimal vascular care (28 percent compared to 41 percent for other payers)
- Controlled high blood pressure (72 percent vs. 76 percent)
- Optimal asthma care for children (18 percent vs. 28 percent)
- Optimal asthma care for adults (11 percent vs. 18 percent)
- Breast cancer screening (61 percent vs. 74 percent)
- Cervical cancer screening (71 percent vs. 77 percent)

- Colorectal cancer screening (47 percent vs. 67 percent)

- Treatment of children's pharyngitis (85 percent vs. 90 percent).

While these differences are sometimes stark, statewide gaps in performance rates between MHCP and other purchasers have decreased for many measures over the last two to eight years.

There is not significant empirical evidence in Minnesota about the factors affecting provider quality. However, qualitative evidence suggest that, among others, the following factors contribute to a culture of improvements in quality of care: a patient-centered focus on quality, available information on quality that is actionable for consumers and providers, a provider structure that permits staff to work to the top of their license, availability of data to practices for structuring care coordination (e.g., patient registries), and success with activating patients.

10. Population health status

Population health status measures

As described above, in general, the health status of Minnesota is relatively strong when compared to other states. According to the United Health Foundation's 2011 Health Rankings Report[48], Minnesota is ranked sixth in the United States in terms of overall health, seventh in health determinants and second in health outcomes. While these are solid rankings, unfortunately, the state's health is declining. In just two years, Minnesota has dropped from second in the country to its current sixth-place position.

[48] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN

In 2012, Minnesota performed a statewide health assessment, *The Health of Minnesota, Statewide Health Assessment,* including measures related to the state's population characteristics, social and economic factors, and health outcomes.[49] The report included a wide array of indicators and information about the conditions and factors affecting health, as well as indicators of health status. Indicators included:

- Mortality and morbidity rates (chronic and infectious diseases)
- Health risk behaviors (physical activity, tobacco and alcohol use)
- Timing of prenatal care initiation
- Birth outcomes, including infant mortality and low birth weight
- Maternal risk factors, including tobacco or alcohol use during pregnancy
- Child/youth adverse experiences, including abuse and neglect
- Teen pregnancy and birth rates
- Preventive health measures (cancer screening, immunizations)
- Prevalence of sexually transmitted infections
- Sexual behavior.

[49] Minnesota Department of Health (2012, April). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf

Social/economic determinants impacting health status

In Minnesota, gains in health status have not been shared equally by all subgroups of the population. Health disparities persist among rural residents, populations of color, immigrant and refugee populations, low-income, and underserved communities. Historical, institutional and personal racism have contributed greatly to these inequities, which in turn lead to poorer health status.[50] The Minnesota statewide health assessment revealed that disparities in health status and health determinants are widespread and persist throughout a person's lifetime: from their education to their employment opportunities and subsequent income; from infant mortality to cancer rates to health care access; and from early childhood through adulthood.[51]

High-risk communities

According to a Minnesota study, people with serious mental illness (schizophrenia, schizoaffective disorder, or bipolar affective disorder) in Minnesota die much earlier than the general population on average.[52] As discussed above, homeless populations, children in state custody, individuals with cultural difference, and individuals with low English proficiency or low health literacy are all particularly vulnerable members of the population and demand particular attention.

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[50] Minnesota Department of Health (2012, April). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf
[51] Minnesota Department of Health (2012, April). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf
[52] Trangle, M., Mager, G., Goering, P., Christensen, R. (2010) Minnesota 10 By 10: Reducing morbidity and mortality in people with serious mental illness. *Minnesota Medicine*, June. Retrieved from http://www.minnesotamedicine.com/CurrentIssue/ClinicalTrangleJune2010/tabid/3466/Default.aspx

Current health status outcomes

Minnesota is considered to be one of the healthiest states in the nation.[53] According to the 2011 America's Health Ranking Report, Minnesota has a low rate of death related to cardiovascular disease, low rate of uninsurance, and a high rate of high school graduation.[54] In the same report, however, low rate of public health funding per capita and a high prevalence of binge drinking was cited as areas of where Minnesota was challenged.[55]

Specific to the measures outlined above, many show trends that are moving in the right direction:

- 56 percent of Minnesota ninth-graders were physically active for 30 or more minutes on at least five of the last seven days in 2010, up from 51 percent in 1998.
- The percentage of adults who are current smokers has declined from 22 percent in 2001 to 15 percent in 2010.
- In 2010, Minnesota women age 40 or older were more likely to receive a clinical breast examination than women in the United States as a whole (84 percent vs. 77 percent), and also more likely receive a mammogram (81 percent vs. 76 percent).
- 72 percent of adults age 65 and older received a flu shot in 2010, up from 63 percent in 1995.

[53] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN
[54] United Health Foundation. (2012). America's Health Rankings: Minnesota State Report. Retrieved from http://www.americashealthrankings.org/MN
[55] Minnesota Department of Health (2012, April). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf

- The proportion of ninth-graders engaging in sexual activity has declined in every racial/ethnic population since 1995. The decline ranges from seven percentage points for white students to more than 20 percentage points for African-American students.

- Minnesota has one of the lowest rates of health disease in the nation, and mortality rates for heart disease have declined in all race/ethnicity groups, and for both men and women, since 1995.

- Infant mortality rates have declined for all racial/ethnic groups over the last 15 years; African-American rates have dropped from 16.5 per 1,000 in 1989-1993 to 10.7 per 1,000 in 2005-2009, and American Indian rates have dropped from 16.5 to 9.4 during the same time period.

However, on a number of measures, trends are moving in the wrong direction:

- Between 1994 and 2010, the percentage of Minnesotans age 65 and older with diabetes has grown from roughly 10 percent to more than 16 percent.

- The percentage of Minnesotans who are overweight or obese has increased from 51 percent in 1995 to 63 percent in 2010.

- The rate of chlamydia infections per 100,000 Minnesotans has increased from 264 in 2006 to 311 in 2010.

- Minnesota's suicide rate has been steadily climbing in the last 10 years, from a low of 8.9 per 100,000 population in 2000 to 11.1 per 100,000 in 2010.

The other factors impacting population health

Once very demographically homogenous, Minnesota's racial and ethnic diversity is increasing rapidly in some areas. As the state's population ages, communities will be confronted with challenges and opportunities in meeting the unique needs of older Minnesotans.[56]

These trends will also impact health care providers; the health care workforce in Minnesota is also rapidly aging, and will face significant retirements in the coming years. As Minnesota's population diversifies, the health care workforce will need to do so as well; substantial research shows that providers of color are more likely to practice in communities with high populations of color, indicating that diversification of the health care workforce may be a powerful lever for improving access.

11. Specific special needs populations

A. Payer information for special needs populations

Overall, about one-third of the state population in 2007 had health care needs that required the taking of medication for conditions that are expected to last 12 months or more.[57] The rate is higher for public program population (40.8 percent) and lower for populations with other coverage or no coverage (32 percent, 27 percent, and 21 percent, respectively for those with group, individual, or no coverage).

[56] Minnesota Department of Health (2012, April). The health of Minnesota, statewide health assessment. Retrieved from http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf
[57] Health Economics Program, Minnesota Department of Health and School of Public Health, University of Minnesota (2008) 2007 Minnesota health access survey.

Nineteen percent of parents with children on public programs report that their child uses more medical care, education, mental health, or other health care services than other children their same age. For children with parents who have group coverage, the rate is about 9 percent. Among children in the state, 14.3 percent are estimated to have special health care needs that include functional difficulties and complex health conditions.[58]

Table Seven: Description of Each Special Needs Population by Payer Type

		Number Served by Payer Type[i]				
Population	**Total Number (Minnesota)**	**Commercial Insurance**	**Medicaid (Fee for Service)[ii]**	**Medicare**	**CHIP**	**Medicaid Managed Care Organizations**
People with substance abuse issues	477,353	25,000[iii]	2,500[iv]			16,000[v]
Children (under 18) with mental health needs	645,000	86,000	7,160[vi]		[vii]	35,840
Adults (18-64) with mental health needs	777,843	12% of all enrollees[viii]	99,402[ix]	10% of Medicare enrollees 65+ 9,581 Medicaid FFS adults		102,562[x]
Seniors (over 65)	700,177		6,242[xi]	586,209 (including duals)		48,504[xii]
Adults (18-64) with Disabilities	270,050 (non-institutionalized)		59,002[xiii]			37,320[xiv]

[58] Child and Adolescent Health Measurement Initiative, Data Resource Center for Child & Adolescent Health (2010). Minnesota Report, 2009/2010 National Survey of Children with Special Health care Needs. Retrieved from http://www.childhealthdata.org/browse/survey

[i] Data is not unduplicated.
[ii] Unless otherwise noted, data in this column is from Thomson Reuters Healthcare Inc., analysis of MMIS data, CY 2006 through CY 2010; data extracted January 2012. Counts validated by Minnesota Department of Human Services staff, May 2012.
[iii] Or 50% of total care
[iv] Or about 10% of fee for service of public pay
[v] Or 40% of public pay
[vi] Rule 5 Children's Residential Treatment, Children's Therapeutic Services and Supports
[vii] Included in MMCO estimate
[viii] Minnesota Council of Health Plans, "A Report from the Minnesota Council of Health Plans: Minnesota's Mental Health", 2008.
[ix] Includes 23,951 individuals receiving additional services
[x] Includes 10,629 individuals receiving additional services
[xi] Duals: 5,974 and Non-Duals: 268
[xii] Duals: 46,758 and Non-Duals: 1,746
[xiii] Duals: 33,603 and Non-Duals: 25,399
[xiv] Duals: 20,575 and Non-Duals: 16,745

B. Factors impacting care, health, and cost for special populations

Patients with chemical dependency issues

Approximately 477,353 individuals in Minnesota are receiving treatment for chemical dependency. However, patients with chemical dependency often struggle with stigma and an associated reluctance to seek help which results in a reduction in the numbers who access care. Therefore, this number likely underrepresents the need for services in the state. However, of those that do access treatment, approximately 50 percent receive services through commercial insurance, 10 percent through Medicaid fee-for-service or public pay and approximately 40 percent through the Medicaid Managed care program.

The availability of specialized treatment services is also not uniform across Minnesota, and, for some special populations, services addressing the population's distinct treatment needs do not yet exist. Specialized chemical health services are needed to ensure the provision of effective services to individuals who present with distinct treatment needs. Individuals in need of, but

lacking access to specialized treatment, do not attain recovery in general population programs at a rate comparable to individuals without distinct needs.

Lack of early identification and intervention in cases of chemical dependencies combined with the lack of consistent referrals by health professionals for help results in symptom progression and ultimately increases the need for more intensive services. Additionally, many Minnesotans lack treatment options near home. Patients requiring public assistance for chemical dependency treatment often experience treatment delays and limited access to services, which can sometimes result in the individual dropping out of the treatment process. Too often, gatekeepers of public and commercial health care alike terminate treatment prematurely, before stability in recovery has been attained, resulting in recurrence of symptoms.

Patients with behavioral health, psycho-social needs

There are approximately 645,000 children with mental health needs in the state and approximately 777,843 adults. In the commercial market, approximately 12 percent of all enrollees access mental and/or behavioral health services. Patients with behavioral health and other psycho-social needs often experience stigma and misunderstanding, which can lead to under-treatment.

Children and youth with mental health needs are particularly likely to be undiagnosed until they have acquired co-morbid conditions, such as substance abuse, learning disorders, and secondary mental health disorders. They have high rates of school dropout, involvement with law enforcement, and unemployment. Further, provider workforce shortages, especially for specialized children's services as well as payment policies that deny coverage for preventive care and other critical behavioral health services, create barriers to appropriate treatment. When

behavioral health and psycho-social needs are not addressed, the costs shifted to or emerge in special education, other health care, child welfare, and juvenile justice.

For adults, major depression is a key cause of absenteeism and disability for adults in the workforce. Depression is also a major factor in recovery time for persons with co-occurring physical disorders.

Adults with serious mental illness are at greater risk for higher need for more costly health care services due to a high incidence of smoking, obesity, diabetes, and cardiovascular or pulmonary disease. A 2011 Robert Wood Johnson report estimates that more than half of disabled Medicaid enrollees with psychiatric conditions also had claims for diabetes, cardiovascular disease or pulmonary disease, substantially higher than rates of these illnesses among persons without psychiatric conditions. [59]

Patients with physical disabilities or cognitive defects including traumatic brain injury and developmental disabilities

Patients with physical disabilities or cognitive defects including traumatic brain injury and developmental disabilities have specialized health care needs that often cannot be adequately met due to a lack of specialty expertise in clinics, especially in rural areas. Additionally a lack of adequate payment for preventive care and other critical services for this population limits their ability to access the high quality care they need and deserve. There are approximately 100,000

[59] Druss, B.G., Walkers, E.R. (2011). Mental disorders and medical comorbidity. Robert Wood Johnson Foundation, research Synthesis Report No. 21. Retrieved from http://www.thenationalcouncil.org/galleries/business-practice%20files/Druss_021011%20policysynthesis%20mentalhealth%20report.pdf

individuals with brain injuries in the state and approximately 563,269 individuals with physical disabilities.[60,61]

Patients with Dementia

Adults with dementia are three times more expensive than an individual without dementia. In addition to their health care needs, they also often require significant social support and assistance with activities of daily living. They tend to have significant challenges with adherence to treatment plans. There are approximately 94,000 adults with dementia in Minnesota.

Part 2: Health System Design and Performance Goals

12. Delivery system transformation

A. Delivery system cost and quality targets

As Minnesota moves toward its delivery system transformation goals, we expect improvement on a number of measures of health care quality, health information exchange, and health system costs. Aggregate cost savings from the Minnesota Model are estimated at $111.1 million over the three-year testing period, with $90.3 million in savings accruing to the Medicaid program. Aggregate net cost savings, after provider reimbursement, are estimated at $61.4 million for Medicaid over the same period.

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[60] Minnesota Brain Injury Alliance (2008). General Information Brochure. Retrieved from http://www.braininjurymn.org/resources/publications.php

[61] Derived from: (1) 2010 Decennial Census, Tabulations by the Minnesota State Demographic Center and by the Minnesota Department of Human Services, Aging and Adult Services Division (2012, March). (2) Erickson, W., Lee, C., & von Schrader, S. (2012). 2010 Disability State Report: Minnesota. Cornell University Employment and Disability Institute (EDI). Retrieved from http://www.disabilitystatistics.org/.

With regard to statewide medical expense targets, the Governor's Health Care Reform Task Force is currently considering statewide targets that could be used to track Minnesota's progress on per capita health care costs. While these discussions are underway, specific targets have not yet been established.[62]

To assess the degree to which actual and planned interventions are having an impact on quality , Minnesota will monitor and report on performance on a subset of Statewide Quality Reporting Measurement System (SQRMS) measures for hospitals and clinics engaged in ACOs (with comparison to those that are not), with the goal of achieving the short-term and long-term targets shown in Table Eight. The significant investments that Minnesota plans to make in electronic health records adoption and health information exchange should also result in significant increases on measures of health information technology adoption and exchange in the coming years. Minnesota will continue to monitor performance on all of these indicators, with the following short and long-term targets:

Table Eight: Minnesota's Delivery System Quality and HIT Targets for 2016 and 2020

Measure	**2010 rate**	**2016 Target**	**2020 Target**
Clinics with an electronic health record	72%	90%	100%
Hospitals with an electronic health record	93%	100%	100%
Nursing homes with an electronic health record	69%	80%	90%
Chiropractic offices with an electronic health record	25%	40%	60%
Pharmacies actively e-prescribing	93%	100%	100%

[62] Governor's Health Care Reform Task Force (2012). Draft recommendations from the Care Integration and Payment Reform Work Group. Retrieved from http://mn.gov/health-reform/images/CIPR-2012-09-04-%20Draft%20Recommendations.pdf

Clinics routinely using preventive care reminders/alerts in EHR	54%	65%	75%
Hospitals using clinical reminders/alerts	41%	55%	70%
Nursing homes routinely using preventive care reminders/alerts in EHR	47%	60%	70%
Clinics able to submit information from EHR to immunization registry	51%	65%	75%
Hospitals able to submit information from EHR to immunization registry	54%	65%	75%
Clinics exchanging health information outside system/network	41%	50%	65%
Clinics exchanging health information with non-hospital/clinic providers	13%	20%	35%
Hospitals exchanging health information outside system/network	43%	50%	65%
Hospitals exchanging health information with non-hospital/clinic providers	16%	25%	40%
Local health departments exchanging health information with MDH	44%	55%	70%
Nursing homes with capability to exchange health information	38%	50%	65%
Optimal care for heart failure patients	83%	87%	92%
Optimal care for adults with high blood pressure	70%	80%	90%
Optimal care for adults with diabetes	28%	40%	50%
Optimal care for adults with vascular disease	34%	45%	55%
Optimal care for children with strep throat	86%	90%	92%
Central Line infection prevention bundle	87%	90%	95%
Mammogram in past two years for women ages 52-69	83%	90%	95%
Pap smear in the past three years for women ages 24-64	80%	85%	90%
Adults ages 51-80 who received colorectal cancer screening	72%	85%	90%
Care Coordination measure (under development)	n/a	tbd	tbd
Patient Experience (CG-CAHPS). Data collection underway.	n/a	tbd	tbd

Proposed New Measures			
All-cause readmission measure	n/a	tbd	tbd
Other measures tbd, as needed: care integration, care for patients with multiple chronic conditions, measures of prevention for children and adults	n/a	tbd	tbd

For a number of SQRMS measures, the Department of Human Services tracks outcomes for Medicaid enrollees against those for other payers. For these and other measures, Minnesota will also set targets for decreasing the disparity in performance between Medicaid/CHIP enrollees and patients who are covered by other payers.

Table Nine: Minnesota's Targets to Reduce Quality Disparities Between Medicaid and Other Payers

Measure	**2011 Disparity (Medicaid vs other payers**	**2016 Disparity Target**	**2020 Disparity Target**
Optimal care for adults with diabetes	12%	9%	6%
Optimal care for adults with vascular disease	13.2%	10%	6%
Optimal care for children with strep throat	5%	4%	3%
Pap smear in the past three years for women ages 24-64	6.5%	4%	3%
Mammogram in past two years for women ages 52-69	13.3%	10%	6%
Adults ages 51-80 who received colorectal cancer screening	19.2%	15%	10%

To supplement the SQRMS measures on which Minnesota already collects data, the state is also developing and will further develop new measures for care coordination (currently under development through the Health Care Homes program), all-cause hospital readmission,

integration of medical and behavioral health care, measures of prevention for children and adults, and care for patients with multiple chronic conditions. A patient experience measure was added to SQRMS in 2011, and data collection that will form the baseline for this measure is currently under way. We will also assess whether any additional measures regarding functional status (such as CDC Healthy Days) would be beneficial to providers and patients. The state will also work with Accountable Communities for Health to establish measures that are appropriate to the priorities and activities of their work, including measures of care integration.

Population health performance targets

Over the next five years, the payment and care delivery changes that are planned in Minnesota will help to move us toward a more efficient, high-quality, patient-focused, integrated model of care that will improve overall population health through better care management and coordination, a strong focus on accountability for cost and quality, and increased consumer engagement. As a result of these and other changes, population health improvements that we expect to see are included in the table below.

Table Ten: Minnesota's Population Health Performance Targets for 2016 and 2020

Measure	Time Period	Baseline	2016 Target	2020 Target
Heart disease mortality	2008-2010	122.7/100,000	111/100,000	101/100,000
Diabetes mortality	2008-2010	18.2/100,000	17.3/100,000	16.4/100,000
Breast cancer mortality	2008-2010	21/100,000	20/100,000	19/100,000
Cervical cancer mortality	2008-2010	1.6/100,000	1.5/100,000	1.4/100,000
Colon cancer mortality	2008-2010	14.6/100,000	13.8/100,000	13.0/100,000
Percent without insurance coverage	2011	9.1%	8.8%	6%
Adults with good/excellent health	2011	66.9%	68%	72%
Adults with 14 or more days of poor physical/mental health in last month	2011	11%	10.5%	10%
Percent of adults with a usual source of care	2011	87.9%	89%	92%
Percent of adults with arthritis	2011	14.7%	15.4%	16.2%

who participate in self-management programs				
Percent of adults with a dental visit in last 12 months	2010	75%	80%	83%
Percent of adults with a physical checkup in last 12 months	2011	69%	72%	76%
Flu shot in last year: age 65+	2010	72%	75%	80%
Other measures tbd, as needed		n/a	tbd	tbd

13. State goals for improving care, population health, and reducing health care costs

Minnesota is committed to improving care at all levels of the health care system. By moving to a model of accountable care the state hopes to:

- Ensure that every patient receives coordinated, patient-centered primary care. Minnesota will work to ensure that everyone has a usual source of care, ideally in the form of a Health Care Home.
- Increase access to quality care. Since insurance status is critical to ensuring access to care, Minnesota will work to increase the rate of residents with insurance,
- Strengthen collaboration and community engagement,
- Increase provider satisfaction.
- Reduce avoidable readmissions and unnecessary system utilization.
- Increase the percent of patients receiving optimal care for acute conditions.
- Increase the percent of patients receiving optimal care for chronic conditions.

- Increase the rate of patients receiving the recommended preventive care.

As described in Section 12 above, the state has identified measures that it will use to track progress against each of these quality goals. Where appropriate, the state has also set specific targets that it hopes to achieve on each measure during the testing period.

A. State goals for population health and improved health

Minnesota's population health goals, listed below, are intended to be broad and aspirational, offering a vision for the future of health in our state. They touch on how people live, the knowledge they possess about their health, and the health care they experience.

- Improve the quality of life for all Minnesotans. Specifically, the state will work to increase the percent of residents that consider themselves to have good or excellent health and increase the number of "healthy days" experienced by all.

- Reduce the mortality rate among individuals with chronic diseases. Specifically, Minnesota will work to reduce the mortality of individuals with heart disease, diabetes, breast cancer, cervical cancer, and colorectal cancer.

As described in other sections, the state has identified measures that it will use to track progress against each of these population health goals. Where appropriate, the state has also set specific targets that it hopes to achieve on each measure during the testing period

B. State goals for reducing health care costs

Minnesota is committed to reducing the total cost of care throughout the system. Public discussions are currently under way, through the Governor's Health Reform Task Force to consider setting specific targets to reduce per capita spending over the course of the next five years.[63] Since costs are so often calculated within the silos of care that exist within the fragmented health system, and usually reflect only costs for medical care, they often do not capture the impact of shifting costs or the impact of short-term cuts on the longer-term budget. Minnesota's ACO model will move toward financial models that account for all of the spending in the system, regardless of the care setting, and will incentivize the various providers to work together to coordinate care and offer patients comprehensive care.

At the state level, the Department of Human Services has made a commitment to reduce costs while improving outcomes among Medicaid enrollees. Decreasing per capita Medicaid costs is one focus of the Minnesota Accountable Health Model that will be tested.

14. Delivery system models and approaches

Minnesota will use the implementation of the ACO contracts to drive the system towards increased care integration and coordination through innovative delivery system models and community engagement. Specifically, through SIM Funding, Minnesota will expand ACOs while providing communities with the flexibility to adopt delivery system models that draw on their community resources and best meet their unique local needs. The state expects that many communities will choose to implement evidence-based strategies such as the Health Care Homes

[63] Governor's Health Care Reform Task Force (2012). Care Integration and Payment Reform Work Group. Retrieved from http://mn.gov/health-reform/health-reform-in-Minnesota/health-care-reform-task-force/care-integration-payment-reform/index.jsp

and Community Health Teams that are already underway, however, communities will not be required to select one of those strategies. These changes in payment structure will also encourage innovation within the delivery system and create opportunities for payers and provider organizations to work together to develop new ways of improving care and population health.

The Minnesota Model will support the movement of the preponderance of providers in the state toward providing and paying for value-based care and achieving the Triple Aim by expanding ACOs through the Medicaid Health Care Delivery Systems (HCDS) accountable care demonstration. To address barriers that currently prevent a greater number of providers across the state from entering into these models, the state will provide incentives and supports through the investments described throughout this plan (e.g., data analytics, health information technology, practice facilitation, learning collaboratives, etc.).

Through this model, Minnesota is building on a foundation that is already in place and many providers have already adopted. Based on a survey conducted in August 2012 under the auspices of the Governor's Health Reform Task Force, health plans in the commercial market reported between one-third and two-thirds of covered lives or spending associated with total cost of care contracts, with higher percentages in the Twin Cities region than elsewhere in the state. Since the model is consistent with the payment reform efforts being implemented in the commercial market, the efforts will build and support one another and lead to a greater adoption and spread of value-based care across the state.

The state will begin its efforts by implementing the nine ACO contracts for the HCDS demonstration. These contracts cover various geographic regions of the state; five of the ACOs

(Fairview, Northwest Metro Alliance (Allina/HealthPartners), Children's, FUHN, Park Nicollet) are located in the Minneapolis/St. Paul metropolitan area and includes about half of the state's and Medicaid's population. The other three ACOs are located outside of metro area, covering significant parts of state, particularly in rural areas including the southeast (Mayo), central Minnesota/St. Cloud area (CentraCare) and the most of the northern part of the state, which include the more populated and rural areas around Duluth and the Fargo/Moorhead area (Essentia). The state will implement these contracts in January 2013. Once implemented, these contracts alone will cover 159 (21%) of Minnesota's primary care clinics and more than 2,500 providers will be operating under total cost of care contracts, covering 25% of the non-dual Medicaid population.

Following the implementation of the initial ACO sites in the HCDS demonstration, the state will expand ACOs by providing incentives for other provider organizations, particularly in the south, southwest, and west-central parts of the state and other provider systems in the Minneapolis/St. Paul metro area to form ACOs and participate in the Medicaid HCDS demonstration and with other payers. The next ACO RFP under HCDS will be open to any provider organizations in the state and will not specifically target a specific geographic region to be as inclusive as possible , but will focus on being inclusive of other providers including behavioral health and long-term care services and supports that serve complex patients.

In *Phase Three* of the model, the state will select Accountable Communities for Health (ACH) with some priority given to areas of the state where providers are preparing for, but have not yet started ACO models under HCDS, Pioneer ACO, or Medicare Shared Savings, or private payers. Resources for Health Care Home expansion, in preparation for ACH establishment, will be

targeted to the west central and southern areas of the state, where fewer primary clinics have adopted care coordination approaches through Health Care Homes.

The majority of Minnesota's largest teaching hospitals and the University of Minnesota Academic Health Center are already moving toward accountable care models. All nine provider organizations that are currently contracting with the Department of Human Services as part of the HCDS demonstration are medical education providers. The list of providers implementing ACOs through the HCDS demonstration includes the Mayo Clinic, Fairview Health Systems, Children's Hospitals and Clinics of Minnesota, and the parent organizations of Regions, Abbott Northwestern, and United Hospitals; together, these entities provide clinical training for the vast majority of Minnesota students and residents in the health professions. Through its expansion of the HCDS model, the state will continue to support public health care entities such as publicly supported university hospitals and faculty practices in their transition to ACO payment models through investment in infrastructure and workforce (technology, capital, and staffing support).

In addition to their participation in accountable care or similar programs, the University of Minnesota is also making important investments in developing a future workforce that is prepared to work in a more coordinated, integrated and patient-centered environment. As the state's largest producer of primary care providers, the University of Minnesota Academic Health Center has begun its own transformation, by emphasizing interprofessional education in both classroom and field settings. This will help clinical practices to redesign their workflow and care teams to accommodate new models of care delivery, and to incorporate new professions such as community health workers and community paramedics, while creating a pipeline for career development for these new professionals. Employers require assistance to integrate these new

providers. The testing funding will be used to support the redesign of the ACO practices to better utilize the knowledge and skills of these new providers.

15. Proposed payment and service delivery models.

Minnesota is applying for Track 1 Testing Assistance under the State Innovation Models funding opportunity to test the Minnesota Accountable Health Model. The Minnesota Model will begin the implementation of ACOs in Medicaid through the Health Care Delivery System (HCDS) demonstration (described in Appendix 15) in alignment with Medicare and commercial payers. The Minnesota Model specifies and will evolve the use of already-established payment reform models but gives providers and communities the opportunity and freedom to innovate and test new delivery system models rather than dictating a specific model. The specific delivery system model adopted by each Accountable Community for Health will be determined in conjunction with partner community organizations by a local needs assessment. This flexibility will ensure that the delivery system is truly responsive to the needs of the community and builds upon the community's strengths.

A. Evidence base for Minnesota Accountable Health Model approach

While ACO payment models that incorporate quality measures are relatively new, they are built on the concept of capitation. Both ACOs and global payments have been implemented for commercial populations and dual eligible populations in Medicaid managed care and demonstrated success at improving quality and reducing costs in the literature.

The concept of global payments recently has been tested in a number of settings and demonstrated positive results.[64] A study published in the August 2012 edition of Health Affairs details the impact of Blue Cross Blue Shield of Massachusetts' "alternative quality contracts" or global budgets on 11 provider organizations in Massachusetts. The study found that participation in the contract over the two-year period led to a savings of 2.8 percent (1.9 percent in the first year and 3.3 percent in the second) compared to a control group. Additionally, the quality of care improved relative to a comparison group.[65]

A second study published in Health Affairs in September 2012 reviewed a partnership between Blue Shield of California and health care providers using an annual global budget for total expected spending and to share risk and savings among partners for providing health care to certain members of the California Public Employees' Retirement System in Sacramento. The study found that the ACO model showed early success based on the ease of implementation and effectiveness in controlling costs. Cost growth was held to approximately 3 percent, based in part on declines in inpatient lengths-of-stay and 30-day readmission rates. The study suggests that models such as total cost of care have the potential to engage providers and achieve cost savings in a short time period.[66]

Several older studies have also demonstrated that shifting payment models away from fee-for - service toward global budgets or capitation has the ability to change physicians' behavior toward

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[64] In addition to the recent studies referenced within the document, there are a number of older studies from earlier efforts at total cost of care in the form of capitation payment. Epstein, A., Begg, C., & McNeil, B. (1986) "The use of ambulatory testing in prepaid and fee-for-service group practices. Relation to perceived profitability." *New England Journal of Medicine*, August 24, *314*(17), pp. 1089-1094; and Murray, J.P., Greenfield, S., Kaplan, S.H., & Yano, E.M (1992). "Ambulatory Testing for Capitation and Fee-for-Service Patients in the Same Practice Setting: Relationship to Outcomes" *Medical Care*, *30*(3) pp. 252-261, retrieved from www.jstor.org/pss/3766220.

[65] Song, Z., Safran, D.G., Landon, B. E., et. al. (2012) "The 'Alternative Quality Contract' Based on a Global Budget, Lowered Medical Spending and Improved Quality." *Health Affairs*, *31*(8). doi: 10.1377/hlthaff.2012.0327

[66] Markovich, P. (2012) "A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in First Two Years." *Health Affairs*, *31*(9).doi: 10.1377/hlthaff.2012.0358

specific patients. One study found that the use of capitation or salaries was associated with a lower rate of hospitalization when compared to fee for services.[67] Another study comparing the rate at which physicians practicing in large fee-for-service groups ordered tests for patients with uncomplicated hypertension, with the rate for physicians practicing in large prepaid groups, found that after adjusting for the patient's age, sex, duration of disease, and severity of disease as measured by pretreatment blood pressure, and for the doctor's year of medical school graduation, the FFS physicians ordered 50 percent more electrocardiograms and 40 percent more chest radiographs. Additionally the fee-for-service doctors reported that they believed that both tests were associated with high profit and costs. [68] These results were replicated in a similar study that examined a single physician group that provided care for hypertensive patients. Ninety-nine patients were enrolled in a capitated insurance plan and compared with 66 patients in a fee-for-service insurance plan. The authors found that after controlling for patients' age, severity of hypertension, and level of co-morbidity, the patients with capitated health insurance plans had fewer laboratory tests and lower overall charges than the fee-for-service patients, with no clinical or statistically significant differences in one-year health outcomes, specifically blood pressure control.[69] These results suggest that the use of certain high-profit, high-cost tests is higher in large fee-for-service groups than in large prepaid groups and, therefore, the use of ACO arrangements would reduce the incentive for physicians to order these high-cost tests unnecessarily.

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[67] Hillman, A.L., Pauly, M.V. & Kerstein, J.J. (1989). "How do financial incentives affect physicians' clinical decisions and the financial performance of health maintenance organizations?" *New England Journal of Medicine,* 321:86-92, retrieved from http://content.nejm.org/cgi/content/abstract/321/2/86;

[68] Epstein, A., Begg, C., & McNeil, B. (1986). "The use of ambulatory testing in prepaid and fee-for-service group practices. Relation to perceived profitability." *New England Journal of Medicine*, *314*(17):1089-1094.

[69] Murray, J.P., Greenfield, S., Kaplan, S.H., & Yano, E.M. (1992). "Ambulatory Testing for Capitation and Fee-for-Service Patients in the Same Practice Setting: Relationship to Outcomes" *Medical Care*, *30*(3):252-261.

However, it is important to heed Don Berwick's 1996 caution about these studies: "…capitation as a payment mechanism is never an isolated factor in determining the patterns of care. The effects of capitation depend on many other factors in the organization of care, such as the form of the delivery system, the risk relation, the cultural norms, and the specific methods used to try to mold physicians' behavior. Unfortunately, the research literature tends to confound these variables. All studies of capitated payment are, in fact, also studies of other factors in the organization of care."

Therefore, while Minnesota believes strongly that shifting the payment model to ACOs will have a significant impact on cost, quality of care, and population health, the effectiveness of the model will also be determined by the delivery reforms that each community adopts in response to the shift in financial incentives. In particular, the state is interested in testing the impact of organizing care into Accountable Communities for Health (ACH) and integrating local community-based resources into the delivery system.

B. Impact of the Minnesota Accountable Health Model

The ACO model supports the transitioning of providers away from the current fee-for-service model, which rewards volume over value, and toward a more rational system that rewards high quality and efficiency. The fee-for-service payment system provides perverse incentives that reward physicians when their patients are sick, pays them more if they order unnecessary and costly tests and does not consider the quality of the care provided — the exact opposite of how we want physicians to behave. Instead ACO arrangements reward physicians who offer high quality, efficient care and keep their patients healthier and out of the system. By paying integrated ACOs one amount for all of the care needed by a patient, providers are incentivized to

use the most efficient means of keeping the patient healthy and out of the system. To protect patients from provider entities that might attempt to simply reduce utilization in order to save money, the ACO arrangements also include quality measures designed to ensure that the care offered meets or exceeds the expectations of patients.

Since entities that offer coordinated and integrated health care are most likely to succeed in a ACO payment environment, the state believes that these efforts will encourage payers and providers to build upon care coordination and integration initiatives such as the multi-payer Health Care Homes, Community Health Teams and Service Coordination Team that are currently under way. These initiatives will provide the infrastructure necessary to address the social and behavioral determinants of health, enhance the primary care system through the use of local public health resources and ultimately lay the groundwork for reducing health disparities.

C. Impact on quality of care

Since ACO contracts hold the provider entities responsible for costs incurred across the spectrum of care, they have significant incentive to ensure that high quality care is provided at all levels with an emphasis on cost-effective preventive and primary care and avoidance of unnecessary or duplicative tests. Under ACO contracting, if the providers are able to improve the quality of care and keep their patients healthier, then they are rewarded financially.

While not required under this model, the implementation of ACO contracts will encourage providers to adopt evidence-based delivery models to improve the quality of care such as becoming a Health Care Homes or integrating their primary care with behavioral health and other services through participation in an Accountable Community for Health. By incenting communities to share in the financial accountability for population health, the Model expands the

pool of entities with a stake in improving outcomes to include providers across the spectrum of care, as well as non-health care entities.

As described earlier in this document, Minnesota will be monitoring performance on a number of statewide quality measures, and anticipates improvement in most or all measures as a result of the Minnesota Model's activities.

D. Impact on experience of care

Since the ACO model incentivizes the use of care coordination since providing more coordinated, better managed care for, in particular, high-cost, high-risk patients will reduce costs through a reduction in emergency department visits, and other costly acute exacerbations of illness while improving the health and quality of life for the patients. From the patient's perspective having well- coordinated care improves the experience of care since it reduces the need for the patient to undergo duplicate testing, communicate his/ her treatment plan and/ or medical history on multiple occasions, be responsible for bringing his/her medical record and/or medication list to visits. Additionally coordinated care reduces the likelihood that patients will receive conflicting treatment advice, which can be frustrating and confusing for patients, or 'fall through the cracks' when trying to manage multiple providers or caregivers. Throughout the Model testing process, Minnesota will be monitoring patient experience measures to ensure that this aspect of the Triple Aim is being met.

E. Impact on health care expenditures

The state will implement ACO contracts within the Medicaid program, which in Minnesota is fully integrated with the CHIP program. The state anticipates that these contracts will reduce the

cost of care and give the state more insight into expected costs, thus allowing for better budget management. and financial sustainability of the program in anticipation of increase enrollment through the implementation of the Affordable Care Act and over time. The state's experiences with ACOs have demonstrated that these contracts have the potential to reduce costs throughout the system.

Aggregate cost savings from the Minnesota Model are estimated at $111.1 million over the three-year testing period, with $90.3 million in savings accruing to the Medicaid program. Aggregate net cost savings, after provider reimbursement, are estimated at $61.4 million for Medicaid over the same period.

Further detail on projected cost savings is included in the narrative associated with the Financial Template.

F. Coordination to align with federal planning for states

Healthy People 2020 and the National Prevention Strategy provide a framework for the overall goals of the Innovation Plan. In alignment with the National Prevention Strategy, the State Innovation Plan is based on the fact that 70 percent of health is determined by factors outside of the health care system,[70] and so focuses on integrating health care with other systems that impact the health of Minnesotans, including mental health, substance abuse, community health, social services, schools, and long-term supports and services. The Innovation Plan also specifically

[70] McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, *21*(2), 78-93.

includes population health goals aligned with Healthy People 2020 leading health indicators such as tobacco, nutrition, access to health services, and mental health.

The articulation of a National Quality Strategy is a requirement of the Affordable Care Act to move toward meeting the Triple Aim of better care, healthy populations and communities, and delivering affordable care. Minnesota's existing quality initiatives are already substantially well aligned with the National Quality Strategy. The proposed initiatives under this submission with result in further close alignment.

More specific detail about the degree of alignment between Minnesota's current and future care delivery system with the National Quality Strategy is detailed below:

1. ***Making care safer by reducing harm caused in the delivery of care.***

   Minnesota is a national leader on hospital-based patient safety initiatives including mandated reporting of adverse events, and partners closely with the state hospital association to develop and implement statewide patient safety improvement initiatives. The state's Statewide Quality Reporting & Measurement (SQRMS) initiative includes additional measures of care safety, including infection measures for care in hospitals and ambulatory surgery centers (Appendix 14).

2. ***Ensuring that each person and family are engaged as partners in their care.***

   Measures included in SQRMS aim to monitor patient satisfaction, including domains of patient centeredness. Separately, the state's Health Care Home (HCH) initiative measures care coordination. As part of this, the state is involved in measurement development and testing on a number of patient satisfaction variables.

3. ***Promoting effective communication and coordination of care.***

Minnesota is currently leading the nation in measure development in the area of rural provider specific measures. In 2012, the state has partnered with hospitals, academia and stakeholders on the development of emergency department transfer measures for rural hospitals. This data will be available for the first time in the third quarter of 2013, adding to data available through HCH measures on care coordination.

4. ***Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.***

The Department of Health focuses on cardiovascular disease through its heart disease and chronic prevention initiatives that are seen as key tools in the 2011-2020 State Plan.[71] On the quality measurement side, those initiatives are combined with measurement on optimal diabetes care in clinics and a range of hospital-based measures fielded through the CMS Hospital Care initiative.

5. ***Working with communities to promote wide use of best practices to enable healthy living.***

The state pursues numerous initiatives with partners that focus on promoting best practices to enable healthy living. Hospitals work in this area through their community benefit strategies and fron- line care and health education.[72] Through the Community Transformation Grant program, the state has funded two rounds of grants to organizations in the state to make sustainable

[71] Minnesota Department of Health (2012). Heart disease and stroke prevention. Retrieved from http://www.health.state.mn.us/cvh/

[72] Minnesota Hospital Association (2012). Community benefit activities. Retrieved from http://www.mnhospitals.org/policy-advocacy/priority-issues/community-benefit-activities

changes that support individual choices about health; meet local needs by supporting local public health agencies through gather science-based best practices, offering technical assistance, and assisting in evaluation; and meaningfully affect preventable risk behaviors in the area of obesity prevention, reduction use, and physical activity.[73]

6. ***Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.***

A number of innovative initiatives are in place in Minnesota that aim at making quality care more affordable through new health care delivery models, including the development of Medicare Pioneer ACOs, ACO and other shared savings initiatives in the commercial sector, as well as the Health Care Delivery System demonstration for the public health insurance program population that forms the basis for the state's proposal.

Model Cost Targets and Savings Estimates

The Minnesota model has the potential to create critical mass to systematically transform the health care delivery system through practice change resulting from changed financial incentives faced by providers, availability of infrastructure supports for analytics, tools for quality improvement, and integration of community services information into clinical care decision-making.

[73] Minnesota Department of Health. Statewide Health Improvement Program. Retrieved from http://www.health.state.mn.us/ship/

The scale-up imagined for ACOs under the Medicaid Health Care Delivery Systems (HCDS) demonstration will result in approximately 190,000 public program covered lives covered in a shared savings/risk arrangement by 2016.

The commercial market already covers between 1/3 of covered lives in total cost of care contracts (approximately 400,000 covered lives in 2011).[74] For the commercial sector we assume conservatively that about 5 percent of the population not in shared savings arrangements (approximately 480,000 member months) will see their care affected by care transformation motivated by the Minnesota model.

For the Medicare Advantage population we assume that about 10 percent of the population currently not in shared savings model (approximately 200,000 covered lives) will see their care affected by care transformation scale-up through the Minnesota model. We assume a greater share of affected members in part because the vast majority of Medicare Advantage members are enrolled in one of the Minnesota-based health plans that are the most active in moving towards innovative, shared savings arrangements[75]

Further detail on cost trend and savings is included in the narrative associated with the *Financial Template.*

Minnesota Accountable Health Model total cost targets by year:

[74] Care Integration and Payment Reform Workgroup of the Governor's Health Care Reform Task Force (2012, summer). Health plan survey.

[75] Unpublished analysis of annual health plan data (2011) indicates that nearly 90 percent of covered lives are in such health plans.

- With the model test intervention, the 4.0 percentage point savings are projected for all three years of the Model Test, distributed evenly across all categories of service for all populations attributed to an ACO. Break down by year is as follows:

  Medicaid

  - Year 1: CY2013 - 2.0 percent points reduction (CY2013/CY2011)
  - Year 2: CY2014 - 1.0 percentage point (CY2014/CY2013)
  - Year 3: CY2015 – 1.0 percent point (CY2015/CY2014)

  Commercial

  - Year 1: CY2013 – 1.5 percent points reduction (CY2013/CY2011)
  - Year 2: CY2014 – 0.75 percentage point (CY2014/CY2013)
  - Year 3: CY2015 – 0.75 percent point (CY2015/CY2014)

  Medicare Advantage

  - Year 1: CY2013 – 1.75 percent points reduction (CY2013/CY2011)
  - Year 2: CY2014 – 0.75 percentage point (CY2014/CY2013)
  - Year 3: CY2015 – 0.75 percent point (CY2015/CY2014)

Aggregate Gross Cost Savings

- Aggregate cost savings from the Model total **$111.1 million over the three-year period** of the demonstration based on the assumptions above. Break down by payer:
  - Medicaid $90.3 million
  - Private/other: $13.3 million
  - Medicare: $7.5 million

Aggregate Net Cost Savings

- Net cost savings after provider reimbursement total $61.4 million over the three-year period for the Medicaid program only; therefore the overall net savings across all payers is $82.2 million ($61.4+$13.7+$7.5).

Section 3: Roadmap for Health System Transformation

16. and 17. Timeline for transformation with milestones and opportunities

Phase One (January – June, 2013):

1. Release final report from the Governor's Health Reform Task Force, a Roadmap to a Healthier Minnesota, with recommendations focused on Access, Care Integration and Payment Reform, Public Health and Prevention and Workforce Development.
2. Fully implement the nine existing Medicaid ACO (HCDS) contracts with organizations across Minnesota.
3. Build stakeholder support to move providers towards models of integration and greater accountability for all services.
4. Implement the provider data feedback system developed for the ACOs participating in the HCDS demonstration, to ensure that providers have access to actionable data for quality improvement and cost analysis. Providers will receive data feedback from DHS via a provider web portal.

Phase Two (July 2013 – June 2014): Expand ACOs under the Medicaid HCDS demonstration in conjunction with other payers, and provide infrastructure support for adoption of evidence-

based best practices around measurement, quality improvement, data exchange and cost reduction.

1. Release another ACO RFP under the HCDS demonstration to expand the number of Medicaid enrollees and other populations served by participating providers by adding new ACOs to the HCDS program, and expanding the services for which ACOs will be held accountable to include mental health and long term care supports and services. By June 2014, the percentage of the Medicaid population covered under ACO arrangements will increase to 50%.
2. Increase capacity among healthcare, behavioral health, social services, local public health, long term care and other providers to securely exchange data and to provide patient-centered, coordinated care in an integrated environment.
3. Develop customized reporting, technical and assistance and training to ACO participating entities, and build the infrastructure to accept clinical data from electronic health records (EHR) from participating ACOs to provide more timely and actionable data that allows ACOS to act more rapidly to improve care management and coordination early in the care cycle.
4. Lay the groundwork for expansion of current three Community Care Teams by documenting best practices for care integration and developing guidelines for governance and gain-sharing to allow this effective model to expand to a broader set of Accountable Communities for Health (ACHs).
5. Working with a Multi-payer Alignment Committee, begin to develop common performance measurement (cost, quality and experience), data analytics feeds and

reporting, payment, risk adjustment and attribution methodologies, and ACO contract requirements.

Phase Three (July 2014 – June 2016): Continue testing ACOs underway, continue infrastructure support for integrated services in ACOs, and expand Accountable Communities for Health.

Develop a robust network of Accountable Communities for Health across the state by providing financial and technical assistance to up to 15 communities for integration of medical, mental/behavioral health, long term care, public health, and social services activities.

Phase Four (June 2016 – December 2017):

Continue monitoring and reporting on the performance of ACOs on quality and cost targets; evaluate effectiveness of Model and refine as necessary

18. Necessary policy, regulatory and/or legislative changes

As described above, Minnesota Model Minnesota is built upon existing state authorities for Health Care Home[76] and the Medicaid HCDS demonstration.[77] The Minnesota Model is further supported by the current discussions within the Governor's Health Care Reform Task Force[78],

[76] Laws of Minnesota 2011, chapter 256B, Section 0751
[77]

[78] Governor's Health Care Reform Task Force (2012). Health Care Reform Task Force. Retrieved from http://mn.gov/health-reform/health-reform-in-Minnesota/health-care-reform-task-force/index.jsp

which has drafted preliminary policy recommendations that support expansion of ACOs in Medicaid, Health Care Homes, and increased community engagement in these reforms.

The Minnesota Model and the State Innovation Plan are framed by national coordinating efforts including Healthy People 2020 and the National Prevention Strategy, focusing on integrating health care with other systems that impact the health of Minnesotans, including mental health, substance abuse, community health, social services, schools, and long-term supports and services. Minnesota's existing quality initiatives are already substantially well aligned with the National Quality Strategy. The proposed initiatives under this submission will result in further close alignment. More details about the degree of alignment between Minnesota's current and future care delivery system and the National Quality Strategy are included in the State Innovation Plan.

B. Multi-payer supported service delivery and/or payment models

Current Minnesota initiatives in both the public and commercial markets, and similar national models, are based on the concept of accountable care (Appendix 16). Based on a survey conducted in August 2012 under the auspices of the Governor's Health Reform Task Force, health plans in the commercial market reported between one-third and two-thirds of covered lives or spending associated with ACO contracts, with higher percentages in the Twin Cities region than elsewhere in the state. Our testing model builds on these initiatives by addressing the current gaps and barriers in the system to facilitate further integration of care within and beyond health care and across traditional funding and service delivery silos, to meet the needs of the whole person.

Private payers and Medicare/CMS are participating in the model by working with the state through the Multi-Payer Consultation Group to develop common performance measurement (cost, quality, and experience), data analytics feeds and reporting, payment, risk adjustment and attribution methodologies, and ACO contract requirements; and participating in the expansion of ACOs in the state along with the Medicaid HCDS demonstration in *Phase Two* of testing. The following private, nonprofit health plans and county-based purchasing plans that are Medicaid MCOs are required to participate in shared savings and shared risk payment arrangement under the HCDS demonstration: Medica, Blue Plus (Blue Cross Blue Shield of Minnesota), HealthPartners, UCare, PrimeWest, South Country Health Alliance, and Itasca Medical Care. Additionally the following health plans have adopted ACO contracts within the Medicare Advantage program that are aligned with the Model: Medica, Blue Plus, HealthPartners, UCare, and Itasca Medical Care.

Local community organizations or governments may become involved in the model by partnering with an ACO to create an Accountable Community for Health (ACH), or through participation in the statewide advisory committees or working groups for the Minnesota Accountable Health Model.

C. Data and evidence to support goals and strategies

During and after the testing period, Minnesota will monitor and report on performance on a subset of Statewide Quality Measurement and Reporting System (SQRMS measures for hospitals and clinics engaged in ACOs (with comparison to those that are not), with the goal of achieving the short-term and long-term targets described in earlier sections of the Innovation Plan. Minnesota will also be collecting data from providers who choose to participate in learning collaboratives or quality improvement projects, to gauge the extent to which evidence-based best

practices are being adopted and target outcomes achieved. Minnesota will also be exploring the development of unique quality, cost, and care coordination measures for ACOs, as well as the development of mechanisms to collect and report on these measures.

In addition to monitoring quality measures at the state level, DHS will use testing funds to provide better data reporting and feedback to providers and resources to develop the capacity for real-time data analytics and quality improvement. Specifically, the state will implement standardized quality measures and reporting measures that will be integrated with a provider data feedback system developed for the ACOs participating in the HCDS demonstration. Providers will receive data-driven performance feedback from DHS via a provider web portal. Making progress in identifying new relevant areas for quality measurement, particularly for high-cost complex populations, including in outcome measures and in patient reported data, is a key strategy to this approach. As a result of these efforts, providers across the state will receive tools and support to improve the care that they provide, and ultimately patient outcomes.

19. Waiver or State plan amendment requirements

In late August 2012, Minnesota submitted a comprehensive Medicaid reform waiver request to CMS titled Reform 2020. This proposal includes numerous delivery system redesign elements, including:

- Redesigning the personal care assistance benefit to enhance consumer choice and provide maximum flexibility
- Supporting people with a serious mental illness who need short-term, specialized

inpatient treatment

- Expanding counseling and transition supports for people who are not yet enrolled in Medicaid but who are considering a move to a nursing home or assisted living.
- Enhancing community living supports in order to improve housing stability and consistency of care for people who are homeless and for people who have high medical costs
- Providing employment supports to people who are at a critical transition phase of life to increase income and independence and reduce or delay applications for disability benefits.

On Aug. 6, 2012, CMS approved Minnesota's state plan amendment for the health care delivery systems (HCDS) demonstration. HCDS will utilize primary care case management authority under §1905(t) of the SSA to provide care coordination and share risk with health care delivery systems for fee-for-service Medicaid enrollees. This is the first state plan approval under CMS' recently announced alternative care model approach. Minnesota's model shares gains and losses on the total cost of care with HCDS ACOs under contract with the state. This model involves continued payment of regular to FFS providers, and a retrospective attribution methodology to determine and share gains and losses on the total cost of a set of core, acute care services. Enrollee free choice of provider is not restricted. Shared savings payments are affected by compliance with reporting and by quality of care and patient experience measures. Minnesota will also integrate this HCDS approach into its MCO contracts for calendar year 2013.

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Appendix 1 – Health Care Reform Task Force

Minnesota Health Care Reform Task Force

The Health Care Reform Task Force was appointed in November 2011 by Governor Dayton under Minnesota Laws 2010, 1st Special Session, article 22, section 4 to provide leadership and advice to achieve better health care, lower costs and healthier communities for Minnesota. Task Force recommendations will be provided to the Governor and legislature by November 30, 2012.

TASK FORCE MEMBERS

Commissioner Lucinda Jesson (Department of Human Services) – CHAIR
Commissioner Mike Rothman (Department of Commerce)
Commissioner Ed Ehlinger (Department of Health)
Senator Sean Nienow
Senator Michelle Benson
Representative Steve Gottwalt
Representative Joe Schomacker
Peter Benner, former Executive Director for AFSCME Council 6 (Inver Grove Heights)
Mary Brainerd, President and CEO, HealthPartners (Bloomington)
Michael Connelly, Senior Vice President - Strategy and Planning, Xcel Energy, Inc. (Minneapolis)
MayKao Hang, President/CEO, Amherst H. Wilder Foundation (St. Paul)
Jan Malcolm, CEO, Courage Center (Golden Valley)
Ralonda Mason, Supervising Attorney, St Cloud Area Legal Services (St. Cloud)
Judy Russell-Martin, MN Nurses Association, Board Member (St. Paul)
Dale Thompson, President and CEO, Benedictine Health System (Cambridge)
Dr. Doug Wood, Professor, Mayo Clinic (Rochester)
Dr. Therese Zink, Professor of Medicine, University of Minnesota (Zumbrota)

WORKING PRINCIPLES- adopted by the Task Force to guide and inform their work

- The outcome of health reform should be to maximize health and functioning for all Minnesotans at a cost that is sustainable for our economy.
- All Minnesotans should have affordable, portable health care coverage and accessible high quality health services at predictable costs.
- We must create and restructure health delivery services and payment approaches to support high-value care that centers around the needs of all Minnesotans.
- Minnesotans should be engaged in their own health and health care, including awareness of the costs, risks, and benefits of health services and health behaviors.
- Health reform should take into consideration that other areas such as education, economic development, housing and transportation have powerful influences on health outcomes.
- Prevention of avoidable health problems and complications should be central to health reform efforts.
- We must reduce health disparities and increase health equity throughout all efforts.
- Minnesotans must prepare for decisions and needs they will face as they age, and we must ensure that our systems of care and financing -- acute and long term care, health care and community-based services-- are prepared to meet these needs.
- We must make the best use of existing resources and build on what's working in the current system.

CONSUMER AND BUSINESS ENGAGEMENT IN HEALTH REFORM

The Citizens League and Bush Foundation are leading a partnership of foundation, community and business organizations to engage Minnesotans in statewide discussions on the future of health and health care in Minnesota. These efforts will inform the work of the Task Force and their final recommendations. For more information: www.citizensolve.org

WORK GROUPS

The work groups began meeting in 2012, chaired by Task Force members in collaboration with state agency staff. The purpose of the work groups is to gather information and provide the full Task Force with policy recommendations on specific topics. Meetings are open and include opportunities for participation from interested parties. The link to information on Task Force and work group meetings is available at www.healthreform.mn.gov . The work groups' membership and charges are outlined below:

Access-Recommendations presented to full Task Force in July 2012
Chair: Ralonda Mason, St. Cloud Area Legal Services Members: Mary Brainerd, MayKao Hang, Representative Gottwalt, Commissioner Jesson, Commissioner Rothman
Charge: Identify opportunities to encourage consumer choices based on quality and cost of care and to support ways for Minnesotans to easily know and get answers about their coverage and care options.

Care Integration/ Payment Reform-Recommendations presented to full Task Force in September 2012
Chair: Dr. Doug Wood, Mayo Clinic Members: Peter Benner, Commissioner Ehlinger, Jan Malcolm, Senator Sean Nienow, Dale Thompson
Charge: Identify opportunities to improve quality of care, lower costs, and provide seamless services for Minnesotans as they move between systems of health care, long term care, mental health, dental and social services.

Prevention/Public Health-Recommendations presented to full Task Force in August 2012
Chair: Michael Connelly, Xcel Energy Members: Senator Michelle Benson, Commissioner Jesson, Jan Malcolm
Charge: Proposing activities to measurably improve the health of Minnesotans through strategies focused on prevention at both the individual and population levels.

Health Workforce--Recommendations presented to full Task Force in May 2012
Chair: Dr. Therese Zink, University of Minnesota Members: Commissioner Ehlinger, Judy Russell- Martin, Representative Joe Schomacker
Charge: Identify opportunities to ensure a sufficient health work force statewide, including primary care, mental health, chemical health, dental and long term care.

KEY TASK FORCE MILESTONES

November 2011– Monthly meetings begin

December 2011 – Review of 2008 MN reforms

January 2012 – Review of state demographic changes and policy implications

February 2012 – Essential Health Benefits discussion

March 2012 – Total cost of care discussion

April 2012 – Global Payment and ACOs discussion

May 2012 – Health Workforce work group preliminary recommendations

June 2012 – Care Integration and Payment Reform discussion; Prevention/Public Health work group update; Report on consumer and business engagement from Citizens League/Bush Foundation

July 2012 – Access work group preliminary recommendations discussion

August 2012 – Prevention/Public Health work group preliminary recommendations discussion

September 2012– Care Integration/Payment Reform work group recommendations presentation

October 2012 – Draft report reviewed

November 2012 – Final report to Governor, Legislature

Appendix 1A – Minnesota State Innovation Plan Visual

Minnesota State Innovation Plan

- Accountable care and payment models
- Patient-centered care, health care homes, integrated care delivery systems

Minnesota Accountable Health Model

ACO Contracts among:

- Medicare ACOs
- State employees
- Commercial payers
- Medicaid/CHIP

Multi-payer alignment of ACO contracts

- Performance measures
- Provider capacity & infra-structure
- Provider data feedback and exchange
- Accountability for a broader set of services

Minnesota Accountable Communities for Health

Building on Community Care Teams to:

- Engage consumers
- Improve population health
- Integrate medical care with mental health, chemical health, community health, public health, social services, schools and long term sup-ports and services.

Appendix 1B – Minnesota Model Track One Testing Plan

Minnesota Accountable Health Model: Testing Plan

"As Is" Current State (2012)

Minnesota State Innovation Plan

- **Accountable Payment Models**
- **Patient –centered care, health care homes, integrated care delivery systems**

Existing Statutory Authority

- Authority to contract directly with providers and implement accountable care models for Medicaid/CHIP

Current State Initiatives

- Health Care Delivery System (HCDS) Demonstration
- Health Care Homes
- HennepinHealth

Key CMMI Initiatives Underway in MN

- Health Care Innovation Awards
- Medicare ACOs/Shared Savings
- Partnership for Patients
- Medicaid Incentives for Prevention of Chronic Disease

Phase I (Jan 2013 - June 2013)

ACO Implementation

- Implement 9 HCDS demonstrations for Medicaid ACOs
- RFP to expand number of providers & members served; focus on mental health, social services & LTC services/supports..

ACO Data Analytics

- Develop RFP; prepare for Medicaid data warehouse & analytics; including multi-payer support

Data Exchange & Infrastructure

- RFPs for EHR /HIE adoption grants to providers & tools for secure and effective use of data.
- Plan for secure gateway for exchange of public health & other data between providers & state.

ACO Measurement

- Develop common performance measurement strategy for ACOs & new measures for Model testing.

Management, Support, Eval.

- Hire staff, create model policies; establish advisory groups

Phase II (July 2013 - June 2014)

ACO Implementation

- Contract negotiations, actuarial analysis and implementation
- Contract to expand number of ACO models & members served

ACO Data Analytics

- Contract for Medicaid ACO data warehouse & analytics for provider data feedback; including multi-payer support

Data Exchange & Infrastructure

- Roadmap for secure exchange: social services, community orgs. & health care
- Grants to ACO providers: EHR/HIT infrastructure; tools/training on privacy & security
- Implement secure gateway for public health data

ACO Measurement

- Develop common ACO quality and cost measures; new quality measures;
- Plan for data collection

Accountable Communities for Health

- Support Community Care Teams as pilot ACH sites
- Develop models for ACH gain-sharing, tools/resources
- Community discussions on structure, goals and governance

Phase III (July 2014 - June 2016)

Data Exchange & Infrastructure

- Implement roadmap for secure exchange among social services, community orgs. & health care.
- Continue grants to ACO providers for EHR/HIT infrastructure
- Continue dissemination of tools and training on privacy & security for providers.

ACO Provider Transformation

- Continue *Phase II* grants & supports.

ACO Measurement

- Begin data collection and monitoring on common ACO quality and cost measures.
- Continue development of new ACO measures, as needed.

Accountable Communities for Health (ACH)

- Continue existing three ACHs
- Release RFP and begin grants to 12 new ACHs.

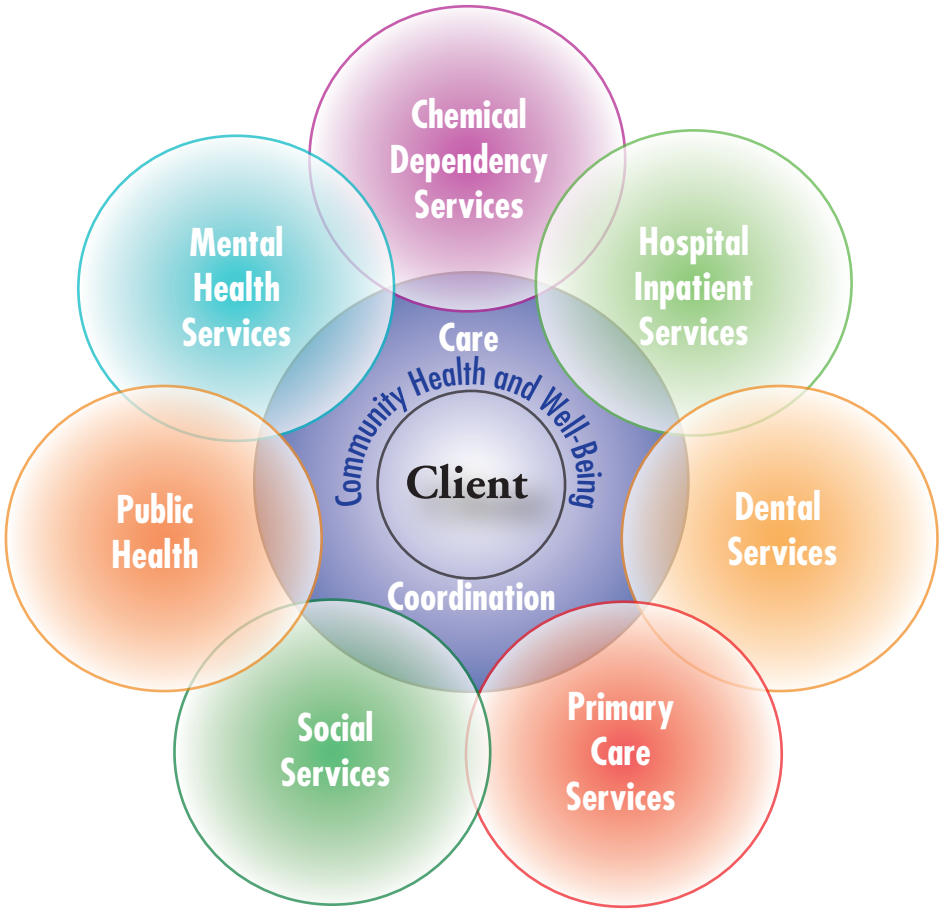
"To Be" Future State (2016 & Beyond)

Vision for Minnesota Accountable Health Model

- Every patient receives coordinated, patient centered primary care
- Providers are accountable for care provided and rewarded based on quality, patient experience and cost performance;
- Financial incentives are aligned across all payers and interests of patients; payment arrangements reward providers for keeping patients healthy and improving quality
- Participating providers partner with communities to integrate medical care with behavioral health, mental health, public health, long term care, social services and other providers.

Appendix 1C – Patient Centered Care in the Minnesota Accountable Health Model

Minnesota Model for Health



Appendix 2A – Health Care Homes by County

Health Care Home Certified Clinics by Minnesota Counties

Minnesota Health Care Homes Per County Sorted By Regions

County	Total 2010 Population	% of Total Population	Region	Total Clinics	Total Health Care Homes	% of Clinics Certified	% Counties in Region Certified Clinics	Certified Clinics per 100,000 people (county)	Certified Clinics per 100,000 people (region)
Carver	91,042	1.7%	METRO	11	2	18%	**100% Metro**	2.20	3.86
Ramsey	508,640	9.6%	METRO	82	22	27%		4.33	
Hennepin	1,152,425	21.7%	METRO	159	44	28%		3.82	
Dakota	398,552	7.5%	METRO	37	16	43%		4.01	
Scott	129,928	2.4%	METRO	8	4	50%		3.08	
Anoka	330,844	6.2%	METRO	22	13	59%		3.93	
Washington	238,136	4.5%	METRO	15	9	60%		3.78	
Aitkin	16,202	0.3%	NE	3	0	0%	**29% NE**	0.00	2.15
Carlton	35,386	0.7%	NE	4	0	0%		0.00	
Cook	5,176	0.1%	NE	3	0	0%		0.00	
Koochiching	13,311	0.3%	NE	4	0	0%		0.00	
Lake	10,866	0.2%	NE	3	0	0%		0.00	
Itasca	45,058	0.8%	NE	8	1	13%		2.22	
St. Louis	200,226	3.8%	NE	37	6	16%		3.00	
Becker	32,504	0.6%	CE	7	0	0%	**63% CE**	0.00	4.74
Benton	38,451	0.7%	CE	1	0	0%		0.00	
Crow Wing	62,500	1.2%	CE	6	0	0%		0.00	
Kanabec	16,239	0.3%	CE	1	0	0%		0.00	
Wadena	13,843	0.3%	CE	2	0	0%		0.00	
Waseca	19,136	0.4%	CE	4	0	0%		0.00	
Cass	28,567	0.5%	CE	9	1	11%		3.50	
Pine	29,750	0.6%	CE	7	1	14%		3.36	
Morrison	33,198	0.6%	CE	5	1	20%		3.01	
Mille Lacs	26,097	0.5%	CE	6	2	33%		7.66	
Wright	124,700	2.4%	CE	10	5	50%		4.01	
Stearns	150,642	2.8%	CE	22	12	55%		7.97	
Chisago	53,887	1.0%	CE	7	5	71%		9.28	
Sherburne	88,499	1.7%	CE	7	5	71%		5.65	
Todd	24,895	0.5%	CE	5	4	80%		16.07	
Isanti	37,816	0.7%	CE	1	1	100%		2.64	
Dodge	20,087	0.4%	SE	1	0	0%	**53% SE**	0.00	2.48
Goodhue	46,183	0.9%	SE	5	0	0%		0.00	
Houston	19,027	0.4%	SE	4	0	0%		0.00	
Le Sueur	27,703	0.5%	SE	6	0	0%		0.00	
Martin	20,840	0.4%	SE	6	0	0%		0.00	
Wabasha	21,676	0.4%	SE	4	0	0%		0.00	
Watonwan	11,211	0.2%	SE	3	0	0%		0.00	
Winona	51,461	1.0%	SE	4	0	0%		0.00	
Blue Earth	64,013	1.2%	SE	11	1	9%		1.56	

Health Care Home Certified Clinics by Minnesota Counties

County	Total 2010 Population	% of Total Population	Region	Total Clinics	Total Health Care Homes	% of Clinics Certified	% Counties in Region Certified Clinics	Certified Clinics per 100,000 people (county)	Certified Clinics per 100,000 people (region)
Faribault	14,553	0.3%	SE	5	1	20%		6.87	
Fillmore	20,866	0.4%	SE	5	1	20%		4.79	
Mower	39,163	0.7%	SE	4	1	25%		2.55	
Cottonwood	11,687	0.2%	SE	6	2	33%		17.11	
Rice	64,142	1.2%	SE	6	2	33%		3.12	
Steele	36,576	0.7%	SE	3	1	33%		2.73	
Freeborn	31,255	0.6%	SE	2	1	50%		3.20	
Olmsted	144,248	2.7%	SE	12	6	50%		4.16	
Clearwater	8,695	0.2%	NW	3	0	0%	**29% NW**	0.00	3.06
Hubbard	20,428	0.4%	NW	2	0	0%		0.00	
Kittson	4,552	0.1%	NW	2	0	0%		0.00	
Lake of Woods	4,045	0.1%	NW	1	0	0%		0.00	
Marshall	9,439	0.2%	NW	1	0	0%		0.00	
Norman	6,852	0.1%	NW	3	0	0%		0.00	
Pope	10,995	0.2%	NW	2	0	0%		0.00	
Red Lake	4,089	0.1%	NW	3	0	0%		0.00	
Redwood	16,059	0.3%	NW	4	0	0%		0.00	
Roseau	15,629	0.3%	NW	3	0	0%		0.00	
Polk	31,600	0.6%	NW	10	2	20%		6.33	
Mahnomen	5,413	0.1%	NW	3	1	33%		18.47	
Beltrami	44,442	0.8%	NW	3	2	67%		4.50	
Pennington	13,930	0.3%	NW	1	1	100%		7.18	
Douglas	36,009	0.7%	CW	5	0	0%	**14% CW**	0.00	0.56
Grant	6,018	0.1%	CW	5	0	0%		0.00	
Otter Tail	57,303	1.1%	CW	9	0	0%		0.00	
Stevens	9,726	0.2%	CW	4	0	0%		0.00	
Traverse	3,558	0.1%	CW	4	0	0%		0.00	
Wilkin	6,576	0.1%	CW	1	0	0%		0.00	
Clay	58,999	1.1%	CW	6	1	17%		1.69	
Big Stone	5,269	0.1%	SW	3	0	0%	**21% SW**	0.00	2.13
Brown	25,893	0.5%	SW	3	0	0%		0.00	
Chippewa	12,441	0.2%	SW	4	0	0%		0.00	
Kandiyohi	42,239	0.8%	SW	6	0	0%		0.00	
Lac qui Parle	7,259	0.1%	SW	4	0	0%		0.00	
Lincoln	5,896	0.1%	SW	4	0	0%		0.00	
Lyon	25,857	0.5%	SW	6	0	0%		0.00	
McLeod	36,651	0.7%	SW	5	0	0%		0.00	
Meeker	23,300	0.4%	SW	6	0	0%		0.00	
Murray	8,725	0.2%	SW	3	0	0%		0.00	
Pipestone	9,596	0.2%	SW	4	0	0%		0.00	
Renville	15,730	0.3%	SW	5	0	0%		0.00	
Sibley	15,226	0.3%	SW	5	0	0%		0.00	

Health Care Home Certified Clinics by Minnesota Counties

County	Total 2010 Population	% of Total Population	Region	Total Clinics	Total Health Care Homes	% of Clinics Certified	% Counties in Region Certified Clinics	Certified Clinics per 100,000 people (county)	Certified Clinics per 100,000 people (region)
Swift	9,783	0.2%	SW	2	0	0%		0.00	
Yellow Medicine	10,438	0.2%	SW	3	0	0%		0.00	
Jackson	10,266	0.2%	SW	4	2	50%		19.48	
Nobles	21,378	0.4%	SW	4	2	50%		9.36	
Rock	9,687	0.2%	SW	2	1	50%		10.32	
Nicollet	32,727	0.6%	SW	3	2	67%		6.11	
MN Total	**5,303,925**			**734**	**184**	**25%**		**3.47**	
Out of State	N/A	N/A	ut of Stat	21	6	29%			

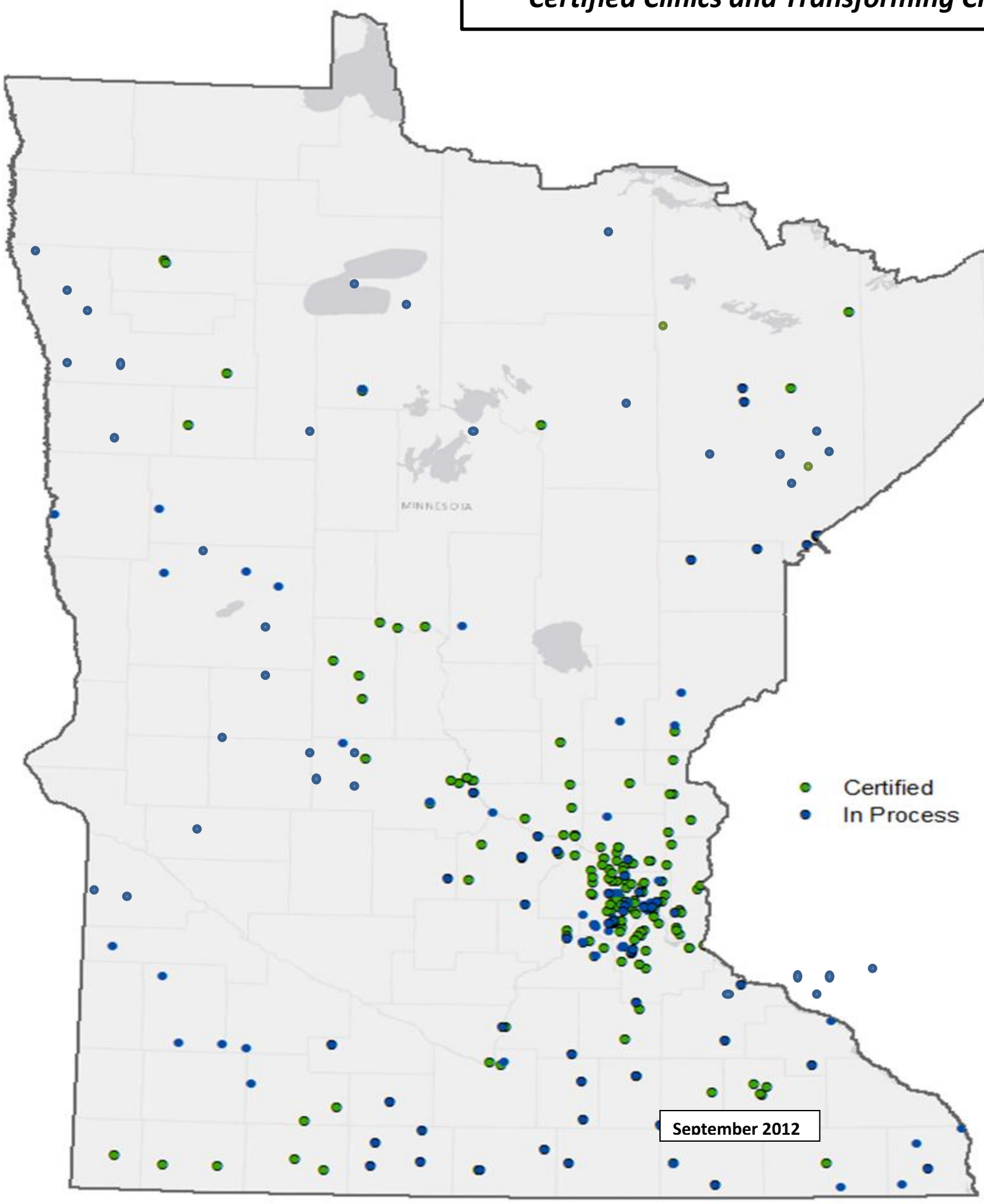
County Data: 2010 Census Redistricting Data (Public Law 94-171) Summary File, Updated in 9/2012

Regions are assigned based on practice faciltator staffing patterns & don't reflect other publically defined MN regions

Appendix 2B – Health Care Homes State Map

Minnesota Health Care Homes:

Certified Clinics and Transforming Clinics



Appendix 3A – Dual Demonstration Purchasing Chart, August 13, 2012

Revised Dual Demo Original Design Model: Special Needs Plan/Medicare Medicaid Integrated Care Organizations 8/13/2012

CMS Medicare Contract and Payment to SNP
Medicare Primary and Acute Care

State Medicaid Contract and Payment to MCO/SNP
Medicaid State Plan and LTSS

MSC+: Medicaid coordinates with Original Medicare

Joint CMS/State Memorandum of Understanding (MOU) for Medicare and Medicaid Managed Care

-Demo under Medicare Advantage Special Needs Plan (SNP) platform and payment structures
-Includes Medicare, Part D, current Medicaid State plan and LTSS (seniors) starting 2013
-SNBC TBD for 2014 Phase 2
-MOU to outline State/CMS oversight roles
- CMS acknowledgement of State payment and delivery reform goals
-"Rules for duals" supports features needed to continue and improve integrated operational features including quality and outcomes measurement and integrated benefit determinations, provider billing and protection from premiums for enrollees

Acronyms

CD-Chemical Dependency
CMS=Centers for Medicare and Medicaid
FFS=fee for service
HCH=Health Care Home
HH=Health Home
ICSP=Integrated Care System Partnership
LTSS=Long Term Services and Supports
MMICO=Medicare Medicaid Integrated Care Organization
MSC+=Minnesota SeniorCare Plus
MSHO=Minnesota Senior Health Options
NF= Nursing Facility
PAC=Post Acute Care
SNBC=Special Needs BasicCare
SNP=Medicare Advantage Special Needs Plan
SMI=Serious Mental Illness
TCOC= Total Cost of Care

SNP MMICO DEMO PLANS
Special Needs Plan Medicare and Medicaid Integrated Care Organizations

Contract Requirements and Risk

Virtual Care Systems
Communication Tools
Model 1

PAC/NF

LTSS

Care Coordination
MMICO/Counties/ Tribes/Community Organizations

Chemical & Mental Health

HCH/Clinic and/or HH

Acute Care

Model 3: Specialized ICSPs Mental, Chemical and Physical Health
-DHS establishes criteria for integrated chemical, mental and physical health care system models for people with SMI enrolled in SNBC under the demonstration
- DHS issues RFP
-Requires partnership between county, MMICO, primary care, chemical and mental health providers
- Could also include non-dual SNBC members
-Additional details TBD with Chemical and Mental Health and Continuing Care
-Exploring Health Homes and/or HCH as part of model
- Standardized outcome measures
-Dependent on viable Medicare financing under demo for dual eligibles with disabilities
-

Model 2: Integrated Care System Partnerships (ICSP)
DHS establishes criteria for model options for ICSPs including:
-Primary care/payment reforms
-Integrated care delivery
-TCOC accountability and options for risk/gain sharing arrangements
--Opportunities for PAC/NF/LTSS/MH/CD providers
-HCH Certification/Transition to HCH
-Enrollee choice of ICSP
-Incentives to serve people across all settings
-Standardized outcome measures
New ICSPs
-DHS Issues RFPs to stimulate additional ICSPs
-Provider/MMICO Partnership required for response
-DHS sets payment and risk/gain options and parameters
Existing Care Systems
-DHS evaluates current care systems arrangements, those meeting or exceeding criteria would be considered ICSPs
-Transition to HCH if not already HCH
-Standardized outcome measures

Market Incentives and Stimulation

Appendix 3B – Dual Demonstration Update, August 2012

Proposed Minnesota MA D-SNP Original Demonstration Features 8-13-2012

A. The State and CMS will enter into an MOU effective January 1, 2013 that provides State involvement in oversight of integrated Medicare and Medicaid contracting arrangements for seniors enrolled in MSHO under the current SNP platform in order to improve the coordination of Medicare and Medicaid services to achieve a more seamless experience for dually eligible beneficiaries.

This initiative will assist the State in meeting its statutory goals for aligning programs for dual eligibles with other State provider payment and delivery reforms including health care home based health care delivery systems called Integrated Care System Partnerships (ICSPs) which are designed to improve overall system performance and care outcomes for dually eligible beneficiaries.

Consistent with CMS' recently announced State Integrated Care Model initiatives, this demonstration will assist CMS by testing administrative features related to implementation of Integrated Care Models outlined in the State's proposal, within the Medicare Advantage Special Needs program context, including:

> **Model 1: Health Care Home based Virtual Integrated Care System Partnerships (Virtual ICSPs)**
> **Model 2: Health Care Home based primary, acute and long term care Integrated Care System Partnerships ICSPs (RFPs for total cost of care systems with risk/gain parameters)**
> **Model 3: Health Home or Health Care Home based Integrated Care System Partnerships focused on integration of behavioral, chemical and physical health for people with mental/chemical illness.**

B. The MOU will include a CMS statement of principle supporting the States payment/delivery reforms outlined above. While Minnesota D-SNPs have implemented such provider payment and delivery reforms under subcontracting arrangements under the current contracting arrangements without demonstration status, allowing a State role in Medicare oversight through the MOU, along with the proposed integrated operational features outlined below will strengthen the State's ability to align programs for dual eligibles with other State reform initiatives and to retain the integrated features necessary to support and expand those reforms across the State in order to measure improvement of overall system performance and outcomes at the plan and provider level for the care of dually eligible beneficiaries.

C. While some of these payment and reform systems are currently in place, assurance is needed that integrated features now in place will remain while we proceed to enhance and expand integrated care delivery models. These features have been worked out under current Medicare Advantage and Medicaid arrangements without special waivers, and include integrated care coordination, the State's TPA system for integrated enrollment, integrated model member materials, integrated benefit determinations and provider billing, and integrated appeals and grievances. However, since they are not subject to any formal agreement between CMS and the State, changes in CMS Medicare Advantage operational policies and procedures periodically threaten to disrupt these

integrated features. Including them in the MOU will <u>provide the stability needed for these current core integrated operations to allow the State to proceed with its implementation of delivery reforms.</u>

D. The MOU will also outline a joint planning process with CMS that will result in a set of "rules for duals" <u>enhancements to the current operational features</u> designed to improve administrative efficiency and test additional integrated operational features between CMS, SNPs and States for implementation in 2014 (or as soon as feasible). While MN has identified a number of specific domains and proposals that should be considered for implementation, we are also aware that CMS is still working out many of the oversight and operational details for other State dual eligible programs under the FAD model. In this planning process, CMS and the State will likely want to consider decisions made in those demonstrations as well as how some features need to be different when working under an MA D-SNP model. Since much of that information is not yet available, we propose that CMS and the State include in the MOU the domains and goals to be addressed and continue to work out further implementation details over the next 3-6 months to finalize those provisions prior to the 2014 call letter issuance in early 2013.

E. The MOU will provide for continued discussions on demonstration opportunities for dual eligibles with disabilities enrolled in SNBC (including the FAD model) in a Second Phase for 2014.

F. The State requests modest budget support to continue demo work, including the integrated dual data base.

G. Evaluation Design: Discussion to be continued. *Evaluate the initiative by focusing on administrative costs while leveraging the existing quality measurements systems in place (e.g., star ratings), without extensive new reporting requirements. An external evaluator would develop case studies to describe operational impacts for plans, the state, and CMS, and potentially quantify administrative costs for plans by examining financial reports and other documents."*

H. "Rules for Duals" Domains to be included in MOU Implementation Work Planning Process:

1. **Continue integrated enrollment processes that simplify the enrollment experience for beneficiaries and improve the accuracy of enrollment process.**
2. **Continue to coordination with CMS to allow integration and simplification of member materials.**
3. **Continue to integrate appeals and grievances including testing of reduced complexity for integrated explanations working with stakeholders.**
4. **State involvement in determination of network adequacy**
5. **Integrate SNP Model of Care.**
6. **Quality Measures and Star Ratings: Test alternative models and adjustments specific to people with dual eligibility**

- **Outcomes Measures (HEDIS)**
- **Special Needs Plan Structure and Process Measures**
- **Health of Seniors Survey (HOS)**
- **Integrate Consumer Assessment of Healthcare Providers and Systems (CAHPs) satisfaction surveys**

7. **Coordination of oversight with CMS including:**
    - **Allow integration of Performance Improvement Projects, Chronic Care Improvement and Disease Management programs**
    - **Secret shopper calls, adjust for issues applicable to dual eligible members**
8. **Preservation of Integrated Benefit Determinations, Provider Billing and Claims Processing**
9. **Beneficiary Protection from Premiums: allow Special Needs Plans to waive premiums of $5.00 or less**

Appendix 4 – Partnerships for Patients

OVERVIEW OF HEN PROGRESS: MINNESOTA HOSPITAL ASSOCIATION

Overview

The Minnesota Hospital Association Partnership for Patients (PfP) Hospital Engagement Network (HEN) consists of 104 hospital members spread across the state. With the implementation of evidence-based campaigns, such as the Reducing Avoidable Readmissions Effectively Campaign (RARE), the Minnesota Hospital Association (MHA) continuously works to monitor and improve the performance of its hospital partners in the area of readmissions.

As part of its involvement in PfP, 43 percent (45 hospitals) of its member hospitals have committed to focusing on all 10 program-defined Adverse Event Areas (AEAs). These efforts, initiated by MHA to meet PfP goals, have yielded certain positive results across the various AEAs.

This report provides an overview of MHA's progress on two focus areas: potentially preventable readmissions and Early Elective Deliveries (EED). The following table shows MHA's commitment level in each of these focus areas along with an overview of their performance results and goals to date.

HEN's Commitment and Performance Levels At-A-Glance

Focus Area	Percent of Hospitals Committed to Addressing Focus Area[1]	Measure	Baseline (# of Hospitals)	Current Performance (# of Hospitals)[2]	Goal
Readmissions	70%	Potentially Preventable Readmissions (PPR) actual to expected (A/E)	**0.975**	**0.89**	**0.8 actual to expected readmissions**
Obstetrical (OB) Adverse Events	88%	# of EEDs not meeting JC exclusion criteria	615 (39)	589 (39)	**0**

Readmissions were identified as MHA's First Focus, or the area in which they believed rapid improvement was most likely. For Readmissions 70 percent of the HEN's eligible hospitals have committed to addressing and measuring improvement, whereas for OB Adverse Events 88% of the hospitals that deliver babies (n=71 of all 81 birthing hospitals) have committed to improvement.

[1] Only includes hospitals eligible for focus area.
[2] Represents the aggregate rate, during the measurement period to date. Also included is the average number of hospitals that reported data during the time period for which the rates were derived.

Readmissions

Overview

As previously mentioned, Readmissions was designated by MHA as its area of First Focus. To meet the 40/20 goal of the PfP, MHA launched a campaign to implement practices within its hospitals that would lead to a reduction potentially preventable readmissions. Currently, 72 member hospitals have pledged to implement readmissions prevention best practices and also report performance measure data.

Goal

MHA's goal is to reduce the ratio of actual potentially preventable readmissions to expected potentially preventable readmissions from **0.975 to 0.8**

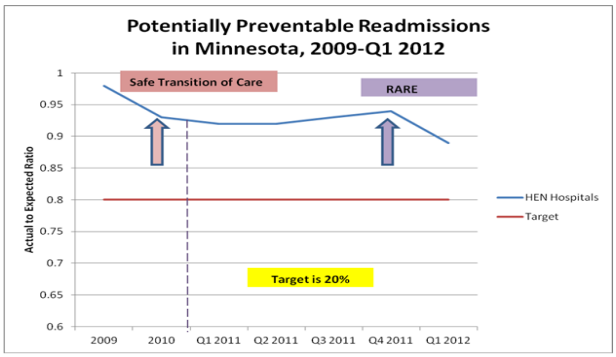
Measurement

MHA uses the ratio of actual preventable readmissions to expected preventable readmissions to measure readmission performance, which is defined below:

$$Readmissions = \frac{\text{Actual \# of potentially preventable readmissions}}{\text{Expected \# of potentially preventable readmissions}}$$

Performance Results

The following figure shows the HEN-reported readmissions from 2009 to the first quarter of 2012 in relation to the goal. Major preventive programs that have contributed to the decreasing ratio are also indicated in the figure.



Achievements

For readmissions, MHA reported the following achievements:

The following three readmission reduction campaigns have been successfully implemented as part of the RARE campaign:

- Eric Coleman's Care Transitions - ICSI
- Project RED - Stratis

- SAFE Transitions – MHA

EED

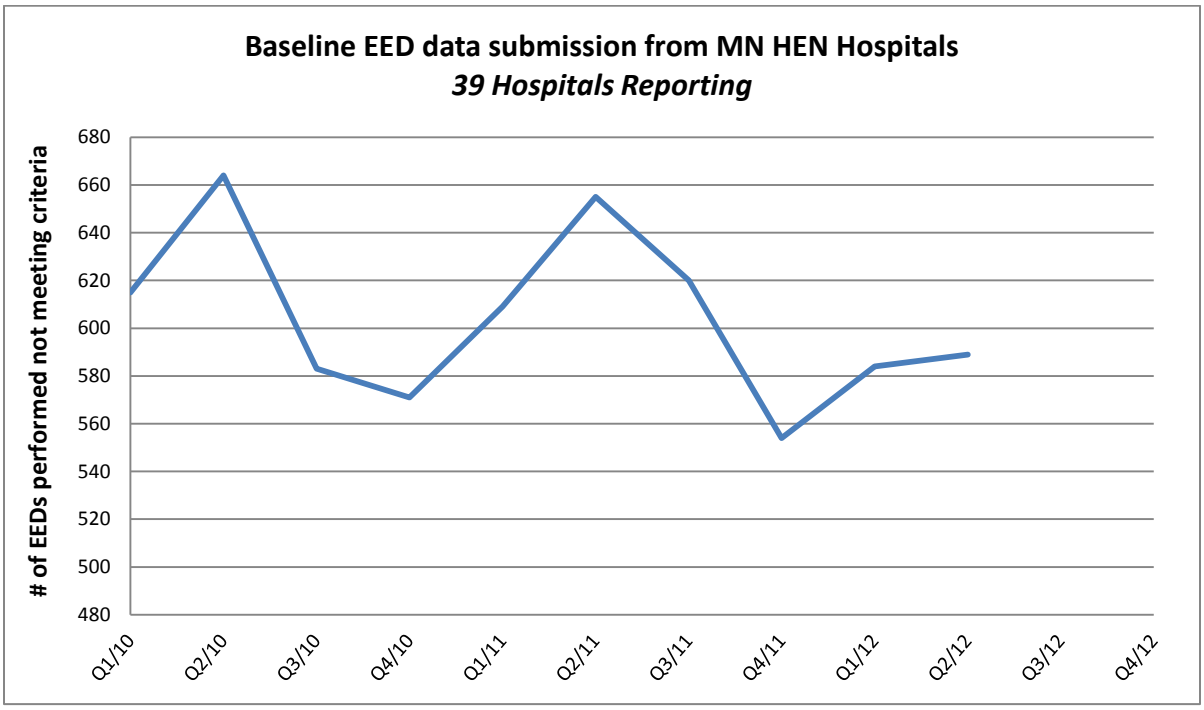
Overview

Of the 104 hospitals making up the MHA HEN, 81 hospitals provide OB services, with approximately 46,775 projected deliveries per year. Of the 81, hospitals, 71 have pledged their involvement with the commissioner from the State of Minnesota, to use evidence based program that will assist the hospitals with implementing a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers. Of the applicable hospitals, 71 of the 81 hospitals had submitted their EED reduction policy by July 20, 2012.

Goal

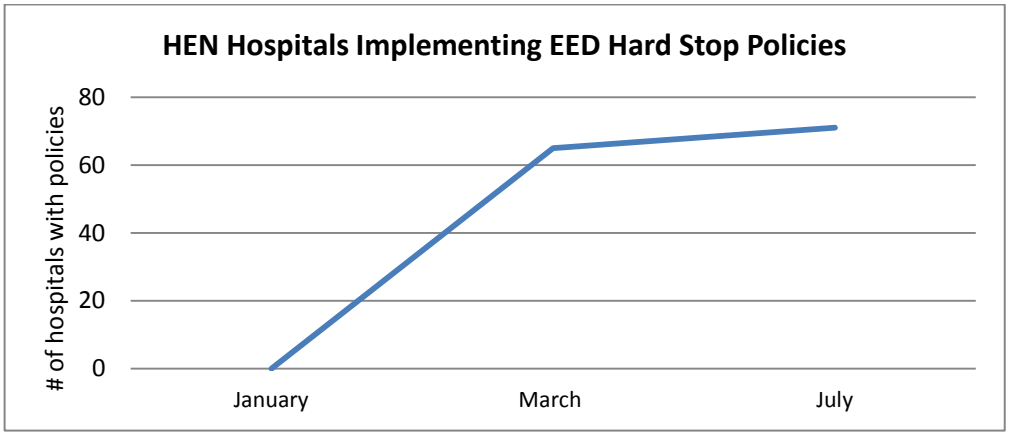
If the HEN reaches its goal of decreasing its current number of EEDs down to zero, the estimated number of avoided EEDs will be around 589. MHA established this goal by committing to a hard stop of EEDs in its 81 eligible hospitals.

Measurement



Performance Results

The following figure shows the number of hospitals within the HEN that have implemented a hard stop procedure.



Achievements

For EED, MHA reported the following achievements, or anticipated achievements:

MHA has been working with the state to get all 81 birthing hospitals to submit the hard stop policy. As of July 20, 2012 only 10 HEN birthing hospitals have not submitted their policy.

Appendix 5 – RARE Initiate Overview

RARE Reducing Avoidable Readmissions Effectively

A Minnesota Campaign

RARE Campaign

- The RARE Campaign is a Minnesota health care community initiative to engage hospitals and care providers across the continuum of care in an intensive effort to reduce avoidable hospital readmissions statewide. The intent is to help patients and their families avoid the burdens caused by unnecessary rehospitalizations, so they can maintain better health and enjoy the comforts of their own homes.
- The campaign seeks commitment from all hospitals in Minnesota, but particularly the 40–50 hospitals that account for roughly 80% of the annual hospital readmissions.
- The campaign recognizes that avoidable hospital readmissions are the result of a fragmented health care system. The campaign will initially recruit hospitals which will then engage other groups in the care continuum that contribute to avoidable readmissions.

Statewide Collaboration

- As Operating Partners, the Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association (MHA) and Stratis Health will manage the operational aspects of the campaign, secure broad stakeholder involvement and collaboration, and keep the campaign moving at an accelerated pace. They are providing the majority of the staffing and resources.
- Supporting Partners, such as Minnesota Medical Association and MN Community Measurement, are providing significant resources and support to develop and implement specific aspects of the campaign.
- A broad and expanding base of Community Partners that include providers, health plans, state health agencies, home health agencies, nursing homes, patient advocacy groups and other community groups are also endorsing and actively supporting the campaign.

Triple Aim Goals

The challenges facing health care in Minnesota require a statewide, concerted effort to achieve the Triple Aim of improving population health, the experience of care, and the affordability of care.

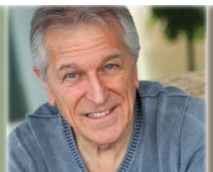
Population Health:

- Prevent 4,000 avoidable readmissions within 30 days of discharge between July 1, 2011 and Dec. 31, 2012, thus avoiding unnecessary rehospitalizations and their associated burdens.
- Reduce the overall readmission rate by 20% (from 5.8% in 2009 to 4.6% by Dec 31, 2012), as measured by MHA Potentially Preventable Readmissions (PPR) Data.[1]

Care Experience:

- Help patients and their families spend 16,000 nights of sleep in their own beds versus in the hospital.
- Improve by 5% the Hospital Consumer Assessment of Healthcare Providers and Systems survey questions related to hospital discharge by end of 2012:
  - Percentage of patients reporting they received information about what to do during their recovery at home will increase by five percentage points from the 2010 baseline level.
  - Percentage of patients reporting that they were not given information about what to do during their recovery at home will decrease by five percentage points from the 2010 baseline level.

1 These goals are based on the following: 1) All Minnesota inpatient admissions (all ages) excluding newborn, oncology, trauma and burn patients; 2) Baseline measure: January 1 to December 31, 2009, and 3) Data source: Minnesota All Payer Potentially Preventable Readmissions (PPR) Data, MHA, a quarterly report beginning in September 2011 that will be provided to all campaign participants and partners.



Affordability of Care:

- Decrease health care costs by avoiding 4,000 preventable readmissions, with preliminary estimates at more than $30 million annually in the commercially insured population. (The cost savings in Medicare will be even higher.)

Approach

- RARE builds upon and expands work that has been going on for several years by many hospitals, medical groups, health plans and the Operating, Supporting and Community Partners.
- The campaign acknowledges that avoidable readmissions are the result of a fragmented care delivery system. Starting with hospitals, the campaign will also aim to improve care across the continuum.
- Operating Partners will engage care provider groups that coordinate and care for patients after discharge. These providers will be kept apprised of the hospitals' efforts and will be increasingly involved in the campaign.
- The campaign will focus on five key areas that, if not managed well, are known to be main contributors to avoidable hospital readmissions: 1) medication management, 2) transition care, 3) patient and family engagement in discharge preparation, 4) comprehensive discharge plan, and 5) transition communications.

Structure and Implementation

1. Leaders from the Operating Partners will contact senior hospital officials to explain the RARE campaign. Hospitals will be asked to commit to participate, meet aggressive but realistic goals, and partner with care delivery organizations to achieve them. Using PPR data, goals will be based on an MHA analysis to show that potential reductions in avoidable readmissions can be made by each hospital in Minnesota.
2. After completing an organizational assessment, hospitals will receive support for selecting the interventions most likely to accelerate their work and achieve success. The number of staff to be involved will be based on the analysis and the hospital's established reduction goals.
3. The five focus areas hospitals can work on each will incorporate the details of recognized best practices. Each focus area will have a designated list of activities for hospitals to complete.
4. Through a collaborative approach, the RARE partnership will provide counsel and best practice toolkits to ensure that hospitals improve and redesign their care processes to achieve their reduction goals.
5. Through an "innovator" approach, some hospitals can take an intensive and highly compressed approach (similar to the process for Lean projects) to identify faster ways to achieve results.
6. Participating hospitals will receive quarterly PPR data from MHA. Hospitals will collect data on a variety of process measures for quality improvement and report their progress.
7. In addition to the quarterly PPR reports provided by MHA, 30-day all cause readmission rates for selected clinical conditions will be publicly reported on MN HealthScores for hospitals and provider groups in 2012.

Timeline

- Operating Partners will recruit hospitals from July through August 2011. The campaign will then run from July 2011 through December 2012.
- Hospitals that are most ready to focus on one or more of the five areas will begin in September. Hospitals less ready at the onset can join the campaign over time. This enables hospitals to tackle a few areas at a time instead of having to deal with all of them at once.

Appendix 6 – Medicaid Diabetes Prevention Incentive Program

We Can Prevent Diabetes MN

The Department of Human Services (DHS) and the Minnesota Department of Health (MDH) were awarded a 5 year, 10 million dollar grant in September 2011 by the Centers for Medicare and Medicaid Services (CMS). The grant funds a research study that will test the effects of incentives on attendance and weight loss among Minnesota Health Care Program beneficiaries participating in the Diabetes Prevention Program. The DHS Office of the State Medicaid Director is the lead organization for this project, known as *We Can Prevent Diabetes MN*. DHS is collaborating with MDH under an interagency agreement, and is contracting with Health Partners Institute for Education and Research, a non-profit research organization, to conduct the study's evaluation and with the YMCA of Greater Twin Cities to provide the Diabetes Prevention Program.

Participants

We Can Prevent Diabetes MN will provide an opportunity for up to 3,200 Minnesota Health Care Program (MHCP) enrollees to participate in a Diabetes Prevention Program (DPP). The DPP is an evidence-based program that has been proven to reduce the conversion to diabetes by 58% over three years in people with pre-diabetes who lose 7 percent of their body weight. Participation in the 16 weekly and 8 monthly DPP sessions will be free to all participants.

The target population for the project is MHCP enrollees between 18 and 75 years of age who have a diagnosis of pre-diabetes or have significant risk for developing type 2 diabetes. Rates of diabetes in this population are high, contributing to significant and growing health care costs. The project will operate in the 7-county Metropolitan area, where the largest number of MHCP enrollees and the most racially and ethnically diverse population in the state are concentrated.

Clinic Partners

The *We Can Prevent Diabetes MN* project will be implemented in Minnesota's health care homes (HCH) and other clinics. Up to thirty-six clinics will be selected to participate in the project through a Request for Proposals (RFP) process. Participating clinics will enroll eligible participants with prediabetes into DPP groups, which will then be randomly assigned to one of three conditions: DPP only, DPP plus individual incentives and DPP plus individual and group incentives. Participants in the two incentives groups will receive non-cash incentives for attendance and attainment of participation and weight loss goals. Participating clinics will be phased in over the three year implementation period, and will agree to participate for at least two years. The selected clinics will receive financial and technical support for their participation.

The Diabetes Prevention Program Groups

DPP sessions will be taught by trained YMCA staff at participating clinics or nearby community locations in separate groups from the YMCA's other on-going programs. YMCA coaches will work with these participants to maintain their successful participation. Clinics will be encouraged to train clinic health navigators, including certified Community Health Workers (CHWs), to provide additional participant support to address transportation and childcare as needed, using study funds.

The Study

The study is being advised by the We Can Prevent Diabetes Advisory Council, which is comprised of representatives from clinics, health plans, public health agencies, and organizations serving the study's target populations, including Stairstep Foundation, Communidades Lationos Unidas en Servicio, the Minnesota Community Health Worker Alliance, WellShare International, the Legal Aid Society of Minneapolis, The University of Minnesota, The Mayo Clinic, Stratis Health, the Minnesota Department of Health and others.

The study's primary goal is weight loss among participants. Information about enrollees' participation and other health indicators (e.g. blood pressure, blood cholesterol and blood glucose levels, smoking status), will be collected at the beginning and end of the study and maintenance of weight loss will be documented, along with cost data. If successful, this project will:

- improve weight loss, reduce diabetes incidence, and improve cardiovascular risk among MHCP enrollees who are at risk for developing diabetes and other chronic conditions,
- demonstrate that prevention of chronic disease risk factors using patient incentives is cost-effective, and
- provide a patient incentive model that can be widely used among MHCP enrollees at risk for developing diabetes and in the emerging health care home environment.

The RFP for clinics to participate was released in August 2012 and applications are currently being reviewed. Successful clinics will be notified in the first week of October, 2012, and clinic training will be held in mid-November. The first set of clinics will enroll participants in the DPP groups in November and December, 2012, with DPP groups starting in January 2013. Additional sets of clinics will participate in the study on a rolling enrollment basis through December 2015. A final report will be issued in December 2016, following completion of the study.

Appendix 7 – Courage Center Innovation Award

Courage Center

Centers for Medicare and Medicaid Services (CMS)
Health Care Innovation Award

What is the CMS Innovation Grant? The CMS Health Care Innovation Challenge is a competitive grant opportunity sponsored by the federal government. Specifically, the funds come from CMS – part of the US Department of Health and Human Services. They were very clear in the criteria needed for successful proposals:

- innovative ideas and new models of providing health services to complex patients – for example, patients with disabilities, chronic diseases and those with complicated social needs such as housing;
- new workforce strategies to maximize the health of complex individuals;
- strategies for sustaining the project over time; and
- save money and reduce the total cost of care (over a three-year period) for the individuals served by the proposed project.

Courage Center submitted a proposal in January 2012. Of over 3,000 project proposals submitted nationally, CMS selected Courage Center in first group of 26 funded projects.

How much was the award? $1,767,667 over three years, with an estimated start date of July 1, 2012.

What will the CMS Innovation Grant pay for? The award will support the continued development of the Courage Center patient-centered primary care clinic, which is a state-certified Health Care Home (HCH). Our HCH is like no other in the state of Minnesota, in that it was designed to meet the unique needs of people with disabilities and very complex medical conditions. At Courage Center, a patient's health care and social services are highly coordinated by an interdisciplinary team. Our data shows this approach avoids unnecessary trips to the emergency room, prevents hospitalizations, and improves health and quality of life.

Fortunately, the CMS grant will pay for many expenses that Courage Center would experience with or without the grant, such as salary costs. The CMS grant will help our "bottom line" and allow us to further demonstrate our value. The primary project components include:

- **Telemedicine.** Telemedicine allows patients to complete visits with their health care provider from home, thereby avoiding complicated and expensive transportation issues. Telemedicine units also allow patients to collect important information related to chronic conditions such as blood glucose or blood pressure readings. This information is then transmitted to the clinic where providers are alerted to changes and problems are addressed early in their course. Telemedicine is supported through in-home volunteers who assist patients with equipment and serve as a trusted resource.
- **Chronic Disease Self Management Program (CDSMP)**. The CDSMP is for patients to learn new strategies to manage and cope with their chronic conditions. It is widely accepted and used nationally in many health care settings as a tool to engage patients. Led by one staff person and one peer, the CDSMP follows a curriculum developed and

studied extensively by Stanford University. CDSMP meets as a group of 10-15 participants over 6 weeks where participants set goals, share strategies and track progress on developing healthier behaviors.

- **Independent Living Services (ILS).** ILS is in-home support to assist people in managing day to day household activities – eg. bill paying, arranging transportation, keeping appointments – with the goal of ensuring independence and life stability. The grant will allow access to ILS for individuals who cannot access this low-cost, in-home service.
- **Payment Reform.** Today's reimbursement system rewards expensive and complicated medical procedures and tests – not rehabilitation and social services provided by Courage Center in order to *prevent* higher medical expenses. A key part of the CMS grant will use data from the federal government to help make the case for better payments for delivering care to individuals with complex needs. In partnership with health plans and the State of Minnesota, Courage Center will seek not just payment increases, but opportunities to be rewarded for improving the health of patients while lowering their overall medical expenses.

Who will be served by the CMS Innovation Grant? The grant will support Courage Center's Health Care Home. Anyone receiving services in the HCH will be part of the grant.

How does the CMS Innovation Grant fit into Courage Center's mission and strategic plan? Courage Center's mission is to empower people with disabilities to realize their full potential in every aspect of life. We value quality and innovation and we seek to be nationally recognized as an innovator. To achieve our vision, according to our current strategic plan, we "***deliver best in class services, lead in public policy, innovate and drive change, and engage in transformational resource development.***" The CMS grant is perfectly positioned at the intersection of these strategies and supports our efforts to continuously work toward client growth, satisfaction and improved outcomes.

How will Courage Center sustain the work after the CMS Innovation Grant ends? The CMS Innovation Grant was awarded to Courage Center with the agreement that the Courage Center HCH model will reduce health care costs. The CMS grant will support our HCH as we continue to enroll new patients and further develop and evaluate our HCH model of care. Our results give us the evidence we need to prove our value to the institutions that pay for health care services and negotiate new arrangements for payment based on outcomes.

What does this mean for Courage Center? It means our unique model is being recognized and held up as a national example of how to best provide primary care to individuals living with disabilities and complex health conditions. The CMS award validates our belief that individuals will be healthier if they are treated as "whole people" through patient centered approaches to care.

Where can I get more information? Check out the Courage Center primary care clinic webpage: Courage Center Primary Care Clinic

Questions? Contact Jennifer Thompson, Grants Manager, 763-230-1320

Appendix 8A – Institute for Clinical System Improvement Innovation Award – COMPASS Overview

COMPASS Narrative

The Care Of Mental, Physical And Substance use Syndromes (COMPASS) consortium consists of the Institute for Clinical Systems Improvement (ICSI) as the lead organization; Community Health Plan of Washington; Kaiser Permanente Colorado; Kaiser Permanente Southern California; Mayo Clinic Health System; Michigan Center for Clinical Systems Improvement; Mount Auburn Cambridge Independent Practice Association (Massachusetts); Pittsburgh Regional Health Initiative; AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington, and HealthPartners Institute for Research and Evaluation.

The COMPASS cooperative agreement with the Center for Medicare & Medicaid Innovation will implement the COMPASS Collaborative Care Management Model (CCMM) for Medicare and/or Medicaid beneficiaries with depression plus diabetes and/or cardiovascular disease in implementation sites in California, Colorado, Massachusetts, Michigan, Minnesota, Pennsylvania, and Washington to improve outcomes in each partner system starting in January 2013.

The CCMM core components include:

- a thorough initial evaluation, including screening for relevant co-morbidities, measuring condition severity, and assessing patient readiness for self-management support
- a computerized registry for care monitoring of both individual patients and overall panel management
- treatment intensification when there is a lack of improvement
- prevention of avoidable hospital and emergency department admissions and readmissions
- care manager(s) with clearly defined roles; supervising local expert physician(s) with clearly defined roles
- aggregate data evaluation and quality improvement

Outcome/process milestones include:

At six months after funding, we will have:

- conducted 100% of the readiness assessments
- trained 100% of the care managers and supervising expert physicians
- achieved 100% of the implementation sites being operational for cohort 1

At 15 months, we will have:

- 8000 Medicare and Medicaid beneficiaries with depression and diabetes(DM) and/or cardiovascular disease enrolled
- at six months from each patient's enrollment, a decrease in PHQ-9 by 5 or a PHQ-9 of less than 10 for 40% of the patients

At three years, we will achieve:

- 20% improvement in diabetes and hypertension control rates
- 20% improvement in patient and clinician satisfaction with care processes
- $25 million dollars in reduction in health care costs for these beneficiaries.

An additional outcome from COMPASS will be the identification of core components and key features of the COMPASS CCMM; job descriptions and support specifics for the new worker roles; and specifications for value-based payment models for different delivery systems.

Appendix 8B – Institute for Clinical Systems Improvement Innovation Award – Driver Diagram

COMPASS

ICSI
INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Care OF Mental, Physical And Substance use Syndromes (COMPASS) Driver Diagram
Version 6

Primary Outcomes	Primary Drivers	Secondary Drivers
Implement the COMPASS Collaborative Care Management Model (CCMM) for Medicare and/or Medicaid patients with depression plus diabetes and/or cardiovascular disease in implementation sites in California, Colorado, Massachusetts, Michigan, Minnesota, Pennsylvania, and Washington to improve outcomes in each partner system by June 2015: • Achieve depression improvement of a decrease in PHQ-9 by 5 or a PHQ-9 of less than 10 for 40% of the patients • Improve diabetes (DM) and hypertension control rates by 20% • Improve patient and clinician satisfaction with care process by 20% • Reduce healthcare costs of Medicare and Medicaid measured patients by $25 million	• Enroll 8000 high-risk MC & MA pts by 15 months • Create high fidelity to the CCMM by system design and operational implementation at each partner	• Create and manage central and local COMPASS leadership & infrastructure • Design the CCMM process and intervention specifics, with option for substance use screening • Develop user friendly training processes, materials, and support; train clinicians and care managers in new roles and effective panel management • Create site registries and protocols, and monitor for effective use • Create and implement enrollment processes with feedback to sites • Create workflows and protocols • Create monitoring & QI systems focused on the data needed to achieve the aims • Support with feedback that care management interventions are being delivered with appropriate new roles • Provide implementation sites with regular feedback against goals for depression, DM, & CVD • Monitor care manager panel size and follow-up • Adapt interventions to decrease hospital readmissions, admissions and emergency room admissions
Identify a sustainable care model that reduces total cost of care: • Identify the core components and key features no later than 6/2015 • Describe the job and support specifics needed for new work roles of care managers and care consultants no later than 6/2013 • Identify the value-based payment models for different delivery systems by 6/2015	• Identify critical model features and coverage needs • Collect all data needed for the job and support specifics of new work roles • Collect accurate and complete partner implementation and operational costs • Create the long-term financial model by data analysis & modeling	• Design implementation and operating cost tools and processes at all partner sites • Ensure complete and timely return of cost data • Design and implement work role data collection system • Discuss payment redesign options with key stakeholders including CMS

The COMPASS) consortium consists of the Institute for Clinical Systems Improvement (ICSI) as the lead organization; Community Health Plan of Washington; Kaiser Permanente Colorado; Kaiser Permanente Southern California; Mayo Clinic Health System; Michigan Center for Clinical Systems Improvement; Mount Auburn Cambridge Independent Practice Association; Pittsburgh Regional Health Initiative; AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington, and HealthPartners Institute for Research and Evaluation.

Appendix 9 – Minnesota Statute 256B.0751 Health Care Homes Legislation

Subdivision 1.**Definitions.**

(a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2.**Development and implementation of standards.**

(a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3.**Requirements for clinicians certified as health care homes.**

(a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Subd. 4.**Alternative models.**

Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from

establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

Subd. 5.**Health care home collaborative.**

By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6.**Evaluation and continued development.**

(a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7.**Outreach.**

Beginning July 1, 2009, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Appendix 10 – Health Care Homes Rule 4764.0010- 0070 Published

1.1 **4764.0010APPLICABILITY AND PURPOSE.**

1.2 Subpart 1. **Applicability.** Parts 4764.0010 to 4764.0070 apply to an eligible provider

1.3 that is an applicant or is certified as a health care home.

1.4 Subp. 2. **Purpose.** Parts 4764.0010 to 4764.0070 establish the standards and

1.5 procedures for certification of health care homes. The purpose of the standards is to

1.6 require health care homes to deliver services that:

1.7 A. facilitate consistent and ongoing communication among the health care

1.8 home and the patient and family, and provide the patient with continuous access to the

1.9 patient's health care home;

1.10 B. use an electronic, searchable patient registry that enables the health care

1.11 home to manage health care services, provide appropriate follow-up, and identify gaps

1.12 in patient care;

1.13 C. include care coordination that focuses on patient and family-centered care;

1.14 D. include a care plan for selected patients with a chronic or complex condition,

1.15 involve the patient and, if appropriate, the patient's family in the care planning process; and

1.16 E. reflect continuous improvement in the quality of the patient's experience, the

1.17 patient's health outcomes, and the cost-effectiveness of services.

1.18 **4764.0020 DEFINITIONS.**

1.19 Subpart 1. **Scope.** The terms used in parts 4764.0010 to 4764.0070 have the

1.20 meanings given them in this part.

1.21 Subp. 2. **Applicant.** "Applicant" means an eligible provider that has applied for

1.22 certification or recertification under parts 4764.0010 to 4764.0070.

1.23 Subp. 3. **Care coordination.** "Care coordination" means a team approach that

1.24 engages the participant, the personal clinician or local trade area clinician, and other

2.1 members of the health care home team to enhance the participant's well-being by

2.2 organizing timely access to resources and necessary care that results in continuity of

2.3 care and builds trust.

2.4 Subp. 4. **Care coordination payment system.** "Care coordination payment system"

2.5 means a system established under Minnesota Statutes, section 256B.0753, subdivision 1,

2.6 or 62U.03, paragraph (a), to compensate health care homes.

2.7 Subp. 5. **Care coordinator.** "Care coordinator" means a person who has primary

2.8 responsibility to organize and coordinate care with the participant in a health care home.

2.9 Subp. 6. **Care plan.** "Care plan" means an individualized written document,

2.10 including an electronic document, to guide a participant's care.

2.11 Subp. 7. **Chronic condition.** "Chronic condition" means a medical condition that

2.12 has lasted at least six months, can reasonably be expected to continue for at least six

2.13 months, or is likely to recur.

2.14 Subp. 8. **Clinic.** "Clinic" means an operational entity through which personal

2.15 clinicians or local trade area clinicians deliver health care services under a common set of

2.16 operating policies and procedures using shared staff for administration and support. The

2.17 operational entity may be a department or unit of a larger organization as long as it is a

2.18 recognizable subgroup.

2.19 Subp. 9. **Commissioner.** "Commissioner" means the commissioner of health.

2.20 Subp. 10. **Commissioners.** "Commissioners" means the commissioners of health

2.21 and human services.

2.22 Subp. 11. **Complex condition.** "Complex condition" means one or more medical

2.23 conditions that require treatment or interventions across a broad scope of medical, social,

2.24 or mental health services.

3.1 Subp. 12. **Comprehensive care plan.** "Comprehensive care plan" means the care

3.2 plan for a participant plus all available and relevant portions of any external care plans

3.3 created for that participant.

3.4 Subp. 13. **Continuous.** "Continuous" means 24 hours per day, seven days per week,

3.5 365 days per year.

3.6 Subp. 14. **Cost-effectiveness.** "Cost-effectiveness" means the measure of a service

3.7 or medical treatment against a specified health care goal based on quality and cost,

3.8 including use of resources.

3.9 Subp. 15. **Direct communication.** "Direct communication" means an exchange

3.10 of information through the use of telephone, electronic mail, video conferencing, or

3.11 face-to-face contact without the use of an intermediary. For purposes of this definition, an

3.12 interpreter is not an intermediary.

3.13 Subp. 16. **Eligible provider.** "Eligible provider" means a personal clinician, local

3.14 trade area clinician, or clinic that provides primary care services.

3.15 Subp. 17. **End-of-life care.** "End-of-life care" means palliative and supportive

3.16 care and other services provided to terminally ill patients and their families to meet the

3.17 physical, nutritional, emotional, social, spiritual, cultural, and special needs experienced

3.18 during the final stages of illness, dying, and bereavement.

3.19 Subp. 18. **Evidence-based guidelines.** "Evidence-based guidelines" means clinical

3.20 practice guidelines that are recognized by the medical community for achieving positive

3.21 health outcomes and are based on scientific evidence and other authoritative sources,

3.22 such as clinical literature.

3.23 Subp. 19. **External care plan.** "External care plan" means a care plan created for a

3.24 participant by an entity outside of the health care home such as a school-based individual

3.25 education plan, a case management plan, a behavioral health plan, or a hospice plan.

4.1 Subp. 20. **Family.**

4.2 A. For a patient who is 18 years of age or older, "family" means:

4.3 (1) any person or persons identified by the patient as a family member;

4.4 (2) legal guardian according to appointment or acceptance under Minnesota

4.5 Statutes, sections 524.5-201 to 524.5-317;

4.6 (3) a health care agent as defined in Minnesota Statutes, section 145C.01,

4.7 subdivision 2; and

4.8 (4) a spouse.

B. For a patient who is under the age of 18, "family" means:

(1) the natural or adoptive parent or parents or a stepparent who live in the home with the patient;

(2) a legal guardian according to appointment or acceptance under Minnesota Statutes, sections 260C.325 or 524.5-201 to 524.5-317;

(3) any adult who lives with or provides care and support for the patient when the patient's natural or adoptive parents or stepparents do not reside in the same home as the patient; and

(4) a spouse.

Subp. 21. **Health care home.** "Health care home" means a clinic, personal clinician, or local trade area clinician that is certified under parts 4764.0010 to 4764.0070.

Subp. 22. **Health care home learning collaborative or collaborative.** A "health care home learning collaborative" or "collaborative" means an organization established under Minnesota Statutes, section 256B.0751, subdivision 5, in which health care home team members and participants from different health care organizations work together in a structured way to improve the quality of their services by learning about best practices and quality methods, and sharing experiences.

Subp. 23. **Health care home team or care team.** "Health care home team" or "care team" means a group of health care professionals who plan and deliver patient care in a coordinated way through a health care home in collaboration with a participant. The care team includes at least a personal clinician or local trade area clinician and the care coordinator and may include other health professionals based on the participant's needs.

Subp. 24. **Local trade area clinician.** "Local trade area clinician" means a physician, physician assistant, or advanced practice registered nurse who provides primary care services outside of Minnesota in the local trade area of a state health care program recipient and maintains compliance with the licensing and certification requirements of the state where the clinician is located. For purposes of this subpart, "local trade area" has

the meaning given in part 9505.0175, subpart 22.

Subp. 25. **Outcome.** "Outcome" means a measurement of improvement, maintenance, or decline as it relates to patient health, patient experience, or measures of cost-effectiveness in a health care home.

Subp. 26. **Participant.** "Participant" means the patient and, where applicable, the patient's family, who has elected to receive care through a health care home.

Subp. 27. **Patient and family-centered care.** "Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

Subp. 28. **Personal clinician.** "Personal clinician" means a physician licensed under Minnesota Statutes, chapter 147, a physician assistant licensed and practicing under Minnesota Statutes, chapter 147A, or an advanced practice nurse licensed and registered to practice under Minnesota Statutes, chapter 148.

Subp. 29. **Preventive care.** "Preventive care" means disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems.

Subp. 30. **Previsit planning.** "Previsit planning" means planning for the participant's visit by reviewing the participant's medical record and, if applicable, communicating with the participant before a health care appointment to review changes in the participant's condition and determine a plan for the visit.

Subp. 31. **Primary care.** "Primary care" means overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions, including end-of-life care when appropriate.

Subp. 32. **Primary care services patient population.** "Primary care services patient population" means all of the patients who are receiving primary care services from the

health care home, regardless of whether a patient has chosen to participate in the health care home.

Subp. 33. **Referral.** "Referral" means a written document, including an electronic document, given by a provider to a participant recommending that the participant receive a consultation for evaluation, treatment, or services from a provider outside of the health care home.

Subp. 34. **Shared decision making.** "Shared decision making" means the mutual exchange of information between the participant and the provider to assist with understanding the risks, benefits, and likely outcomes of available health care options so the patient and family or primary caregiver are able to actively participate in decision making.

Subp. 35. **Specialist.** "Specialist" means a health care provider or other person with specialized health training not available within the health care home. This includes traditional medical specialties and subspecialties. It also means individuals with special training such as chiropractic, mental health, nutrition, pharmacy, social work, health education, or other community-based services.

Subp. 36. **State health care program.** "State health care program" has the meaning given in Minnesota Statutes, section 256B.0751, subdivision 1, paragraph (f).

Subp. 37. **Statewide quality reporting system.** "Statewide quality reporting system" means a system used by the commissioner to collect data necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on outcomes.

Subp. 38. **Variance.** "Variance" means a specified alternative or an exemption from compliance to a requirement in parts 4764.0010 to 4764.0070 granted by the commissioner according to the requirements of part 4764.0050.

4764.0030CERTIFICATION AND RECERTIFICATION PROCEDURES.

Subpart 1.**Eligibility for certification.**

A. An eligible provider, supported by a care team and systems according to the

requirements in part 4764.0040, may apply for certification as a health care home.

B. A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home. It is the clinic's responsibility to notify the department when a new clinician joins a certified clinic and intends to become a certified clinician. The clinic has 90 days from the date of hiring the new clinician or until its next annual anniversary date to apply for recertification, whichever is sooner. A clinic may operate as a certified clinic with the new clinician acting as though certified until the new clinician is certified. If the clinician chooses not to be certified, the clinic will no longer be certified, but the clinicians who were previously certified as part of the clinic will automatically hold an individual certification only.

Subp. 2. **Contents of application.** The applicant must submit the following to the commissioner:

A. a completed self-assessment in a form prescribed by the commissioner which describes how the applicant meets the requirements in part 4764.0040;

B. a completed and signed application form prescribed by the commissioner; and

C. any other information required by the commissioner to show that the applicant meets the standards for certification or recertification.

Subp. 3.**On-site review and additional documentation.** The commissioner may conduct an on-site review and may request additional documentation to determine whether the applicant complies with certification or recertification requirements.

Subp. 4. **Completed application for certification.** An application for certification or recertification is complete when the commissioner has received all information in subpart 2; the on-site review, if any, has been completed; and the commissioner has received any additional documentation requested under subpart 3.

Subp. 5. **How to seek recertification.** To retain certification, a health care home must submit a letter of intent stating its desire to be recertified no later than 60 days before

the one-year anniversary of its last certification or recertification and do the following:

A. At the end of year one, an applicant must demonstrate:

(1) the requirements for initial certification continue to be met; and

(2) the requirements for the end of year one for each health care home standard in part 4764.0040 are met.

B. At the end of year two and all subsequent years, unless the applicant obtains a variance for superior outcomes and continued progress on standards as provided in part 4764.0050, subpart 3, an applicant must demonstrate:

(1) the requirements for initial certification and recertification at the end of year one continue to be met; and

(2) the requirements for recertification at the end of year two in part 4764.0040, subpart 11, are met, including the requirement that the applicant's outcomes in its primary care services patient population achieve the benchmarks for patient health, patient experience, and cost-effectiveness established by the commissioner under subpart 6.

Subp. 6. **Benchmarks.** The commissioner must announce benchmarks for patient health, patient experience, and cost-effectiveness annually. The benchmarks must be based on one or more of the following factors:

A. an improvement over time as reflected by a comparison of data measuring quality submitted by the health care home in the current year to data submitted in prior years;

B. a comparison of data measuring quality submitted by the health care home to data submitted by other health care homes;

C. standards established by state or federal law;

D. best practices recommended by a scientifically based outcomes development organization;

E. measures established by a national accrediting body or professional association; and

F. additional measures that improve the quality or enhance the use of data currently being collected.

Subp. 7. **Notice of decision and timelines.**

A. The commissioner must notify an applicant in writing regarding whether the applicant is certified or recertified as a health care home within 90 days after receiving a completed application.

B. If the commissioner certifies or recertifies the applicant as a health care home, the health care home is eligible for per-person care coordination payments under the care coordination payment system.

C. If the commissioner denies the application for certification or recertification, the commissioner must notify the applicant in writing of the reasons for the denial. The applicant may file an appeal under part 4764.0060.

4764.0040HEALTH CARE HOME STANDARDS.

Subpart 1.**Access and communication standard; certification requirements.** The applicant for certification must have a system in place to support effective communication among the members of the health care home team, the participant, and other providers. The applicant must do the following:

A. offer the applicant's health care home services to all of the applicant's patients who:

10.18 (1) have or are at risk of developing complex or chronic conditions; and

10.19 (2) are interested in participation;

10.20 B. establish a system designed to ensure that:

10.21 (1) participants are informed that they have continuous access to designated

10.22 clinic staff, an on-call provider, or a phone triage system;

11.1 (2) the designated clinic staff, on-call provider, or phone triage system

11.2 representative has continuous access to participants' medical record information, which

11.3 must include the following for each participant:

11.4 (a) the participant's contact information, personal clinician's or local

11.5 trade area clinician's name and contact information, and designated enrollment in a

11.6 health care home;

11.7 (b) the participant's racial or ethnic background, primary language,

11.8 and preferred means of communication;

11.9 (c) the participant's consents and restrictions for releasing medical

11.10 information; and

11.11 (d) the participant's diagnoses, allergies, medications related to chronic

11.12 and complex conditions, and whether a care plan has been created for the participant; and

11.13 (3) the designated clinic staff, on-call provider, or phone triage system

11.14 representative who has continuous access to the participant's medical record information

11.15 will determine when scheduling an appointment for the participant is appropriate based on:

11.16 (a) the acuity of the participant's condition; and

11.17 (b) application of a protocol that addresses whether to schedule an

11.18 appointment within one business day to avoid unnecessary emergency room visits and

11.19 hospitalizations;

11.20 C. collect information about participants' cultural background, racial heritage,

11.21 and primary language and describe how the applicant will apply this information to

11.22 improve care;

11.23 D. document that the applicant is using participants' preferred means of

11.24 communication, if that means of communication is available within the health care home's

11.25 technological capability;

12.1 E. inform participants that the participant may choose a specialty care resource

12.2 without regard to whether a specialist is a member of the same provider group or network

12.3 as the participant's health care home, and that the participant is then responsible for

12.4 determining whether specialty care resources are covered by the participant's insurance;

12.5 and

12.6 F. establish adequate information and privacy security measures to comply with

12.7 applicable privacy and confidentiality laws, including the requirements of the Health

12.8 Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts

12.9 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota

12.10 Statutes, chapter 13.

12.11 Subp. 2.**Access and communication standard; recertification at the end of year**

12.12 **one.** By the end of the first year of health care home certification, the applicant for

12.13 recertification must demonstrate that the applicant encourages participants to take an active

12.14 role in managing the participant's health care, and that the applicant has demonstrated

12.15 participant involvement and communication by identifying and responding to one of the

12.16 following: participants' readiness for change, literacy level, or other barriers to learning.

12.17 Subp. 3.**Participant registry and tracking participant care activity standard;**

12.18 **certification requirements.** The applicant for certification must use a searchable,

12.19 electronic registry to record participant information and track participant care.

12.20 A. The registry must enable the health care home team to conduct systematic

12.21 reviews of the health care home's participant population to manage health care services,

12.22 provide appropriate follow-up, and identify any gaps in care.

12.23 B. The registry must contain:

(1) for each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any; and

(2) sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition.

Subp. 4.**Participant registry and tracking participant care activity standard; recertification at the end of year one.** By the end of the first year of health care home certification, the applicant for recertification must use the registry to identify gaps in care and implement remedies to prevent gaps in care such as appointment reminders and previsit planning.

Subp. 5.**Care coordination standard; certification requirements.** The applicant for certification must adopt a system of care coordination that promotes patient and family-centered care through the following steps:

A. collaboration within the health care home, including the participant, care coordinator, and personal clinician or local trade area clinician as follows:

(1) one or more members of the health care home team, usually including the care coordinator, and the participant set goals and identify resources to achieve the goals;

(2) the personal clinician or local trade area clinician and the care coordinator ensure consistency and continuity of care; and

(3) the health care home team and participant determine whether and how often the participant will have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care

B. uses health care home teams to provide and coordinate participant care, including communication and collaboration with specialists. If a health care home team includes more than one personal clinician or local trade area clinician, or more than one care coordinator, the applicant must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each participant and inform the participant of this designation;

C. provides for direct communication in which routine, face-to-face discussions take place between the personal clinician or local trade area clinician and the care coordinator;

D. provides the care coordinator with dedicated time to perform care coordination responsibilities; and

E. documents the following elements of care coordination in the participant's chart or care plan:

(1) referrals for specialty care, whether and when the participant has been seen by a provider to whom a referral was made, and the result of the referral

(2) tests ordered, when test results have been received and communicated to the participant;

(3) admissions to hospitals or skilled nursing facilities, and the result of the admission;

(4) timely post discharge planning according to a protocol for participants discharged from hospitals, skilled nursing facilities, or other health care institutions;

(5) communication with participant's pharmacy regarding use of medication and medication reconciliation; and

(6) other information, such as links to external care plans, as determined by the care team to be beneficial to coordination of the participant's care

Subp. 6.**Care coordination standard; recertification at the end of year one.** By the end of the first year of health care home certification, the applicant for recertification must enhance the applicant's care coordination system by adopting and implementing the following additional patient and family-centered principles:

A. ensure that participants are given the opportunity to fully engage in care planning and shared decision-making regarding the participant's care, and that the health care home solicits and documents the participant's feedback regarding the participant's role in the participant's care;

B. identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants;

C. permit and encourage professionals within the health care home team to practice at a level that fully uses the professionals' training and skills; and

D. engage participants in planning for transitions among providers, and between life stages such as the transition from childhood to adulthood.

Subp. 7.**Care plan standard; certification requirements.** The applicant for certification must meet the following requirements:

A. establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. The applicant must do the following in creating and developing a care plan:

(1) actively engage the participant and verify joint understanding of the care plan;

(2) engage all appropriate members of the health care team, such as nurses, pharmacists, dieticians, and social workers;

(3) incorporate pertinent elements of the assessment that a qualified member of the care team performed about the patient's health risks and chronic conditions;

(4) review, evaluate, and, if appropriate, amend the care plan, jointly with the participant, at specified intervals appropriate to manage the participant's health and measure progress toward goals;

(5) provide a copy of the care plan to the participant upon completion of creating or amending the plan; and

(6) use and document the use of evidence-based guidelines for medical services and procedures, if those guidelines and methods are available;

B. a participant's care plan must include goals and an action plan for the following:

16.10 (1) preventive care, including reasons for deviating from standard

16.11 protocols;

16.12 (2) care of chronic illnesses;

16.13 (3) exacerbation of a known chronic condition, including plans for the

16.14 participant's early contact with the health care home team during an acute episode; and

16.15 (4) end-of-life care and health care directives, when appropriate; an

16.16 C. the applicant must update the goals in the care plan with the participant as

16.17 frequently as is warranted by the participant's condition.

16.18 Subp. 8.**Care plan standard; recertification at the end of year one.** By the end

16.19 of the first year of health care home certification, the applicant must ask each participant

16.20 with a care plan whether the participant has any external care plans and, if so, create a

16.21 comprehensive care plan by consolidating appropriate information from the external plans

16.22 into the participant's care plan.

16.23 Subp. 9.**Performance reporting and quality improvement standard;**

16.24 **certification requirements.** The applicant for certification must measure the applicant's

17.1 performance and engage in a quality improvement process, focusing on patient experience,

17.2 patient health, and measuring the cost-effectiveness of services, by doing the following:

17.3 A. establishing a health care home quality improvement team that reflects the

17.4 structure of the clinic and includes, at a minimum, the following persons at the clinic level:

17.5 (1) one or more personal clinicians or local trade area clinicians who

17.6 deliver services within the health care home;

17.7 (2) one or more care coordinators;

17.8 (3) two or more participant representatives who were provided the

17.9 opportunity and encouraged to participate; and

17.10 (4) if the health care home is a clinic, one or more representatives from

17.11 clinic administration or management;

17.12 B. establishing procedures for the health care home quality improvement team

17.13 to share their work and elicit feedback from health care home team members and other

staff regarding quality improvement activities;

C. demonstrating capability in performance measurement by showing that the applicant has measured, analyzed, and tracked changes in at least one quality indicator selected by the applicant based upon the opportunity for improvement; and

D. participating in a health care home learning collaborative through representatives that reflect the structure of the clinic and includes the following persons at the clinic level:

(1) one or more personal clinicians or local trade area clinicians who deliver services in the health care home;

(2) one or more care coordinators;

(3) if the health care home is a clinic, one or more representatives from clinic administration or management; and

(4) two or more participant representatives who were provided the opportunity and encouraged to participate with the goal of having two participants of the health care home take part; and

E. establishing procedures for representatives of the health care home to share information learned through the collaborative and elicit feedback from health care home team members and other staff regarding information.

Subp. 10.**Performance reporting and quality improvement standard; recertification at the end of year one.** By the end of year one of health care home certification, the applicant for recertification must:

A. participate in the statewide quality reporting system by submitting outcomes for the quality indicators identified and in the manner prescribed by the commissioner;

B. show that the applicant has selected at least one quality indicator from each of the following categories and has measured, analyzed, and tracked those indicators during the previous year:

(1) improvement in patient health;

(2) quality of patient experience; and

(3) measures related to cost-effectiveness of services; and

C. submit health care homes data in the manner prescribed by the commissioner to fulfill the health care homes evaluation requirements in Minnesota Statutes, section 256B.0752, subdivision 2.

Subp. 11.**Performance reporting and quality improvement standard; recertification at the end of year two and subsequent years.**

A. By the end of the second year of certification as a health care home, and each year thereafter, the applicant must continue to participate in the statewide quality reporting system by submitting outcomes for the additional quality indicators identified and in the manner prescribed by the commissioner.

B. To qualify for recertification, the applicant's outcomes in primary care services patient population must achieve the benchmarks for patient health, patient experience, and cost-effectiveness established under part 4764.0030, subpart 6.

4764.0050VARIANCE.

Subpart 1.**Criteria for variance.** At certification or recertification, the applicant may request a variance or the renewal of a variance from a requirement in parts 4764.0010 to 4764.0040. To request a variance, an applicant must submit a petition, according to the requirements of Minnesota Statutes, section 14.056, and demonstrate that the applicant meets the criteria in item A or B.

A. If the commissioner finds that the application of the requirements, as applied to the circumstances of the applicant, would not serve any of the rule's purposes, the commissioner must grant a variance.

B. If the commissioner finds that failure to grant the variance would result in hardship or injustice to the applicant, the variance would be consistent with the public interest, and the variance would not prejudice the substantial legal or economic rights of any person or entity, the commissioner may grant a variance.

Subp. 2.**Conditions and duration.** The commissioner may impose conditions on the granting of a variance according to Minnesota Statutes, section 14.055. The commissioner may limit the duration of a variance and may renew a variance.

Subp. 3.**Variance for superior outcomes and continued progress on standards.** The commissioner may grant a variance to the requirements in part 4764.0030, subpart 5, item B, based on superior achievement reflected in the outcomes data and continued progress on the health care home standards in part 4764.0040. The commissioner must annually announce benchmarks for superior achievement based on the factors in part 4764.0030, subpart 6. To receive the variance, the applicant must:

A. demonstrate that the applicant has met or surpassed the benchmarks for superior achievement in outcomes related to patient health, patient experience, and cost-effectiveness, as reflected in the data submitted by the applicant to the statewide quality reporting system;

B. submit a signed statement affirming that the applicant continues to comply with the requirements for initial certification, recertification at the end of year one, and recertification at the end of year two, according to part 4764.0040;

C. demonstrate continued progress on the health care home standards by identifying at least one approach that is new to the applicant for each of the five health care home standards in part 4764.0040, except for the standard for performance reporting and quality improvement;

D. provide any additional documentation of superior outcomes and continued progress on standards requested by the commissioner; and

E. continue to participate in a health care home learning collaborative.

Subp. 4.**Experimental variance.** The commissioner may grant a variance from one or more requirements to permit an applicant to offer health care home services of a type or in a manner that is innovative if the commissioner finds that the variance does not impede the achievement of the criteria in Minnesota Statutes, section 256B.0751, subdivision 2, paragraph (a), and may improve the health care home services provided by the applicant.

Subp. 5.**Variance for justifiable failure to show measurable improvement.** The commissioner may grant a variance to a health care home seeking recertification that fails to show measurable improvement as required by parts 4764.0030, subpart 5, item B, subitem (3), and 4764.0040, subpart 11, if the applicant demonstrates the following:

A. reasonable justification for the applicant's inability to show required measurable improvement; and

B. a plan to achieve measurable improvement in the following year or a shorter time period identified by the commissioner.

4764.0060APPEALS.

Subpart 1.**Denial of certification or recertification and time for appeal.** The commissioner must notify an applicant in writing of the reasons for denial of an application for certification or recertification. An applicant has 30 days from the date of receiving notice of the decision to appeal the decision.

Subp. 2.**How to appeal.** The applicant may appeal by submitting either item A or B, or both:

A. a written statement of the applicant's grounds for disputing the commissioner's decision; or

B. a corrective action plan that describes the following specific actions for improvement:

(1) the corrective steps that have been taken by the applicant;

(2) a plan for continued improvement; and

(3) if applicable, any reasons that the applicant is unable to comply.

Subp. 3.**Optional request for meeting.** Upon request, an applicant is entitled to a meeting with the commissioner's designee to discuss disputed facts and findings, present the applicant's corrective action plan, or both.

Subp. 4.**Notice of decision and timeline.** The commissioner must grant or deny the appeal and notify the applicant of the decision within 60 days after receipt of a completed appeal, or, if the applicant meets with the commissioner's designee, within 60 days after

the meeting.

4764.0070REVOCATION, REINSTATEMENT, AND SURRENDER.

Subpart 1.**Revocation.** If the commissioner denies an appeal or a health care home fails to appeal the commissioner's decision to deny recertification, the provider will no longer be certified as a health care home or be eligible to receive per-person care coordination payments.

Subp. 2.**Reinstatement.** A provider whose certification as a health care home has been revoked may apply for reinstatement. If the provider was previously certified for one year or longer at the time of revocation, it must meet the recertification requirements to be reinstated. During the 12 months following revocation of certification, the provider may obtain technical or program assistance from the Minnesota Department of Health and through a health care home learning collaborative to assist the provider to regain certification.

Subp. 3.**Surrender.** A health care home may voluntarily surrender the health care home certification by providing the commissioner and the health care home participants with 90 days' written notice. After the expiration of the 90-day notice period, a provider that has surrendered health care home certification is no longer eligible for per-person care coordination payments based on certification.

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*
History: *34 SR 591*
Posted: *January 13, 2010*

Appendix 11 – Hennepin Health Summary

Hennepin Health

An Integrated Health System-Demonstration Project

I. Summary

Hennepin County's proposed integrated health care delivery network is designed to serve the unique needs of two of the most challenging and costly segments of the county's safety net population. By integrating medical, behavioral health, and human services in a patient-centered model of care, the project seeks to improve health outcomes dramatically and lower the total cost of providing care and services to this population.

This project will measure not only direct Medicaid costs, but also health care costs beyond the medical assistance benefit set, including uncompensated care, human services, and public health costs. The project also will quantify law enforcement, correctional, and court costs and savings, as well as the impact on community agency costs.

The project involves shared risk among partners and incentives based on performance and outcomes.

II. Premise

Treating a safety net patient's medical problems without addressing underlying social, behavioral, and human services barriers and needs, produces costly, unsatisfactory results -- both for the patient and the programs providing and paying for care. Conversely, addressing all of these issues and incorporating them into a coordinated patient centered, comprehensive care plan should end the cycle of costly crisis care.

III. Objectives

Implement a patient centered care model that:

- Improves the enrollees' quality of life and improves the patient experience
- Improves the quality of care;
- Improves the provider/staff experience
- Reduces cost to the county, the state, and the federal government;
- Reduces health/social disparities in the target population;
- Is sustainable and can be replicated throughout the state and in other parts of the country.

IV. Target Population

A group of approximately 10,000 individuals per month will participate in the project.

This initial target population will be 18- to 64-year-old adults, with no dependent children in the home, living in Hennepin County, with incomes at or below 75% of the Federal Poverty Guidelines ($677/month or $8,124/year for one person) who qualify for Medical Assistance (MA). This population often receives minimal preventive care, is at high risk for acute care

needs, and has poor health outcomes and health status. This is precisely the population that will benefit most from the proactive, comprehensive, and integrated care management offered by the project.

Below are some defining characteristics of this population,

- ~ 68% Minority status
- ~ 45% Some level of chemical dependency
- ~ 42% Mental health needs
- ~ 30% Chronic pain management
- ~ 32% Unstable housing situation
- ~ 30% More than one chronic disease (diabetes and/or heart disease are most common)

Overlap with ~60% of the population having at least one of these

V. Core Elements

- A patient centered care approach based on the medical home concept
- An integrated system of providers providing comprehensive care, (i.e., emergency, inpatient and outpatient services, primary care, dental care, mental health and substance abuse services, and public health and human services)
- A comprehensive electronic health record (EHR) accessible by the patient and all members of the patient's health care team
- A comprehensive patient assessment tool, with an objective tiering system to identify patients with the greatest needs
- Personalized care plans crafted with enrollees as partners, incorporating medical and behavioral care and human services
- Designation of a health care team that includes medical, behavioral health, and human services professionals for each patient based on the patient's unique needs
- Ability to leverage Hennepin County housing and social service programs, resources, and community partners
- An integrated data warehouse and analytics infrastructure supporting timely, actionable feedback to members, providers, and administrators

Hennepin Health is implementation ready with core staff, core partnerships, and electronic health records currently accessible.

Contact Person:
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Video available at: **www.hennepin.us/healthcare**

Appendix 12 –Health Care Delivery Systems Demonstration – Minnesota Law 256B.0755

256B.0755 HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the delivery system demonstrations;

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems; and

(12) coordinate projects with any coordinated care delivery systems established under section 256D.031.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

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(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) A health care delivery system demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

(e) The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in a health care delivery system.

(b) Eligible applicants and recipients may enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a county, the applicant or recipient shall be allowed to choose among the delivery systems. The commissioner may assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, and rural clinics to the extent practicable.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing

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payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall explore the expansion of the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration.

History: *1Sp2010 c 1 art 16 s 19*

NOTE: This section, as added by Laws 2010, First Special Session chapter 1, article 16, section 19, is effective July 1, 2011. Laws 2010, First Special Session chapter 1, article 16, section 19, the effective date.

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Appendix 12A – Hennepin Ramsey Pilot- Minnesota Law 256B.0755

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

History: *1Sp2010 c 1 art 16 s 20,48*

NOTE: This section became effective January 5, 2011, the date Governor Mark Dayton signed Executive Order 11-01. Laws 2010, First Special Session chapter 1, article 16, section 48.

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Appendix 13 – Health Care Delivery Systems Demonstration – Request for Information

REQUEST FOR INFORMATION (RFI)
Minnesota Department of Human Services Health Care Administration (HCA)

Health Care Delivery Systems Demonstration Project

Purpose and Objective

This document is a request for comments regarding certain aspects of the demonstration project to test alternative and innovative health care delivery systems serving Minnesota Health Care Programs (MHCP) populations authorized under Minnesota Statutes § 256B.0755 (the statute language is attached as APPENDIX A).

These demonstrations allow the Minnesota Department of Human Services (DHS) to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care.

DHS is pursuing a number of related strategies in an effort to improve the value and reduce the cost of the care provided to individuals enrolled in the state's public programs. DHS intends to align the goals, measures and outcomes of these various efforts to the extent feasible.

Response to this RFI is completely voluntary. The State is seeking information that it may use for future planning, policy development, and/or competitive contracting for professional/technical services. This RFI, and responses to it, does not in any way obligate the State, nor will it provide any advantage to respondents in potential future Requests for Proposals for competitive procurement. Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI.

All responses to this RFI are public, according to Minnesota Statutes § 13.03 unless other wise defined by Minnesota Statutes § 13.37 as "Trade Secrets". If the Responder submits information that it believes to be trade secret/confidential materials, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this Response, the Responder must clearly mark every page of trade secret materials in its Response at the time the Response is submitted with the words "Trade Secret" or "Confidential," and must justify the trade secret designation for each item in its Response. If the State should decide to issue an RFP and award a contract based on any information received from responses to this RFI, all public information, including the identity of the responders, will be disclosed upon request.

Request for Information Schedule

State Register Posting:	March 28, 2011
Deadline for Questions:	5:00 PM Central Daylight Time, April 1, 2011
Answers Published:	5:00 PM Central Daylight Time, April 8, 2011
Final submission date:	5:00 PM Central Daylight Time, April 15, 2011

Background and Goals of the Project

State and federal legislation enacted in 2010 seek to improve the quality of health care services and lower the costs of health care through redesign of the delivery of care and the alignment of payments to encourage innovations.

The goal of the Health Care Delivery Systems Demonstration Project is to improve the quality and value of the care provided to the citizens served by both the public programs and the private insurance market. This program will create a structure for provider organizations to voluntarily contract with DHS to care for MHCP patients (both fee-for-service and managed care) under a payment model that holds these organizations accountable for the cost of care and quality of services provided to this population. Within this structure, DHS plans to implement demonstration projects in different parts of the state and across different models of care delivery that will integrate health care with mental health providers, safety net providers, and social service agencies wherever possible. The projects will include clear incentives for quality of care and targeted savings, and will result in increased competition in the marketplace through direct contracting with providers. DHS is seeking input on the definition of the payment model, performance measures, and other program rules through this RFI.

To meet these goals, DHS will develop a request for proposals (RFP) for provider entities interested in participating. The first step in that process is this RFI. In addition, DHS will host stakeholder input sessions to get feedback from organizations and individuals in the community. DHS will use the input from this RFI along with the input from the stakeholder meetings to develop the final RFP, and will then select projects for the implementation of the demonstration from among the pool of responses to the RFP. DHS will also seek the necessary federal authority to implement the demonstration project.

In addition to the targeted feedback requested in this RFI, DHS has been directed under the statute to develop additional measures, models and policies for the Health Care Delivery Systems Demonstration Project. DHS will establish a uniform statewide method of forecasting utilization and cost for public programs, will identify required covered services, and will coordinate this demonstration with other state health reform initiatives underway at DHS and the Minnesota Department of Health (MDH) such as health care homes, provider peer grouping, and the Statewide Health Improvement Program (SHIP).

Response Content

DHS is seeking *detailed*, *specific*, *targeted*, and *actionable* feedback on the following topics:

<u>Opportunities to Increase Value</u>

The provider entities eligible for the demonstration are defined in the statute. DHS is directed to use maximum flexibility to encourage innovation and variation in provider collaborations across the state.

- What models of care are most likely to increase the value of care provided to MHCP enrollees in the demonstration? Include an explanation of effective policies, strategies, and mechanisms to ensure:

- strong primary care and coordination with organizations including but not limited to community social service agencies (required in statute), mental health professionals, public health agencies, long term care facilities, and inpatient rehabilitation facilities,
- coordination with specialists and inpatient providers,
- coordination of care for all patients including those with complex or chronic illness,
- systems for consumer advocacy and protection,
- involvement and partnership with patients and families in their care,
- shared governance between provider entities (including legal structures) necessary for the success of the demonstration, and
- the use of timely and actionable data by the care delivery system to facilitate care coordination and track key performance outcomes (e.g. avoidable Emergency Department visits and total cost of care) during the demonstration period.

Payment Models

It is widely believed that multi-payer alignment is crucial to the success of large scale care delivery and payment reform efforts like this demonstration, both to ensure adequate population size for the assumption of provider risk and to send a consistent "signal" in the marketplace for how providers will be held accountable for which outcomes.

- Are there payment models emerging in the community that DHS should consider for greater alignment of public and private payment systems?
- What payment models should DHS consider in addition to the total cost of care and risk/gain sharing models mentioned in the statute?

Performance Measures

In addition to the total cost of care, the statute requires providers to accept responsibility for the quality of care using standards and measures specified by DHS.

- Keeping in mind the unique and complex MHCP populations served by the demonstration, which specific measures would you recommend be used to evaluate:
  - Quality?
  - Access?
  - Patient satisfaction/experience?
  - Improved health of the population (including functional status and quality of life)?

  Please indicate which measures are already in use and whether they have been endorsed locally or nationally. Indicate if a measure has yet to be developed. Explain how the measures proposed represent a comprehensive indication of the overall quality of care delivered through the demonstration project.
- Outcome measures will be appropriately risk adjusted wherever possible. What special considerations should DHS make in developing risk adjustment strategies for the populations

served in the demonstration? Please be as specific as possible in explaining how risk adjustment should take into account patients' severity of illness, patients' demographics, and other factors impacting the overall cost and quality of patient care. Additionally, please discuss how DHS should most appropriately balance the administrative burden on health care providers of collecting risk adjustment data while needing to demonstrate transparency and accountability within the new delivery model.

- How should the performance measures listed above be incorporated into the payment models adopted in the demonstration?
- What data could participating payers make available to participating providers to better enable them to improve the value of care?

Patient Attribution

The process of attributing or enrolling MHCP enrollees with a health care delivery system is important to ensure that expenditures, as well as any savings achieved by participating providers are appropriately calculated and that quality and performance are accurately measured. This can be done "passively" by linking enrollees to providers based on their past utilization, or "actively" by prospectively assigning enrollees to providers.

- What policies or standards would you recommend for linking enrollees with providers or systems and attributing their costs and outcomes to that provider or system?
- How should DHS weigh the pros and cons of the attribution approaches described above?
- Describe the relationship between retaining enrollee choice of providers and ensuring the ability of participating providers to influence outcomes for a defined population across the spectrum of care.
- Describe the mechanisms necessary to ensure patient access to services and processes to appeal service denials.

Assumption of Risk

It is anticipated that providers will be able to take on varying amounts and types of risk based on the size and complexity of the population they serve, the breadth of services they deliver directly, and the degree of integration across the spectrum of care.

- What policies or standards should DHS use to determine the levels of financial risk permissible for providers in this demonstration and to determine when providers need to enter into third party risk mitigation agreements?
- What types of risk sharing options should be available to participating providers?

Federal Authority

The payment reform envisioned in the demonstration project will require additional federal authority to comply with Medicaid law and regulations. There are a number of ways that DHS could seek this expanded authority (such as through a state plan amendment, a waiver, or a yet-to-be-defined partnership with the newly-formed CMS Center for Innovation), which could impact the timeline in which the demonstration could be implemented.

- How should DHS weigh the likely trade-off between more iterative reforms that can be implemented more quickly and more aggressive wholesale changes that may take longer?

Evaluation

- How should DHS evaluate this demonstration project?

Procedures and Instructions

Responses: Please email an electronic copy of your responses in PDF format to ross.owen@state.mn.us, using the subject line: "RFI: Health Care Delivery Systems Demonstration Project". Include a name, title, address, telephone number and e-mail address of whom to contact in the event there are questions regarding your submission. Sessions may be scheduled to permit oral presentation of or further questions for selected responses. Responses are to be submitted by the deadline stated in the schedule above. It is the responder's sole responsibility to ensure that their submittal is received at the proper email address.

Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI. All submissions, questions, concerns or communications regarding this RFI should be emailed to:

Ross Owen
Minnesota Department of Human Services
Health Care Administration
E-mail: ross.owen@state.mn.us

APPENDIX A : Statute Language

256B.0755 HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the delivery system demonstrations;

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems; and

(12) coordinate projects with any coordinated care delivery systems established under section 256D.031.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) A health care delivery system demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

(e) The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in a health care delivery system.

(b) Eligible applicants and recipients may enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a

county, the applicant or recipient shall be allowed to choose among the delivery systems. The commissioner may assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, and rural clinics to the extent practicable.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall explore the expansion of the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration.

History: 1Sp2010 c 1 art 16 s 19

NOTE: This section, as added by Laws 2010, First Special Session chapter 1, article 16, section 19, is effective July 1, 2011. Laws 2010, First Special Session chapter 1, article 16, section 19, the effective date.

Appendix 14 – Minnesota Statewide Quality Reporting and Measurement System

Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

October 2011

Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550
www.health.state.mn.us

Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

October 2011

For more information, contact:
Division of Health Policy
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Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape.
Printed on recycled paper.

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INTRODUCTION

Minnesota Statutes 62U.02 requires the Commissioner of Health to establish standards for measuring health outcomes and develop a standardized set of measures to assess the quality of health care services offered by health care providers. In addition, Minnesota Statutes 62U.02 requires the Commissioner of Health to issue annual public reports on provider quality using a subset of measures from the standardized set of measures. The Department of Health has contracted with Minnesota Community Measurement (MNCM) to lead a consortium of organizations, including Stratis Health, the Minnesota Medical Association (MMA), the Minnesota Hospital Association (MHA), and the University of Minnesota School of Public Health, to assist in the completion of these tasks.

Measures that will be used for public reporting are identified in Appendices A, B and C. The standardized set of measures are defined in the body of the rule and include the measures identified in Appendices A, B, C, and D. The hospital measures in Appendix B and the ambulatory surgical center measures in Appendix C are defined by the referenced national quality organizations and will likely change over time as modified by the national quality organizations.

APPENDIX A
REQUIRED PHYSICIAN CLINIC QUALITY MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
Diabetes		
Optimal diabetes care (ODC) composite These measures are used to assess the percent of adult patients who have type I or type II diabetes with optimally managed modifiable risk factors: ▪ HbA1c control (less than 8 percent) ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure (BP) control (less than 140/90 mm Hg) ▪ Daily aspirin use if patient has diagnosis of ischemic vascular disease (IVD) or valid contraindication to aspirin ▪ Documented tobacco free *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the optimal diabetes care measure and for each of the five component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and presence / absence of ischemic vascular disease (IVD) co-morbidity: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion	Optimal Diabetes Care Specifications, 2012 (2011 Dates of Service). MN Community Measurement. Revised 08/08/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
	criteria ▪ Calculated rate	
Cardiovascular Conditions		
Optimal vascular care (OVC) composite These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed modifiable risk factors: ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure (BP) control (less than 140/90 mm Hg) ▪ Daily aspirin use or contraindication to aspirin ▪ Documented tobacco free *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the optimal vascular care measure and for each of the four component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and presence / absence of diabetes co-morbidity: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria	Optimal Vascular Care Specifications, 2012 (2011 Dates of Service). MN Community Measurement. Revised 08/08/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
	▪ Calculated rate	

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in February 2012 (February 1, 2011– January 31, 2012 Dates of Service) and Every Year Thereafter		
Behavioral Health Conditions		

Depression remission at six months
 	
This measure is used to assess the percent of adult patients who have major depression or dysthymia who have reached remission at six months (+/- 30 days) after being identified as having an initial PHQ-9 score greater than 9. Remission is identified as a PHQ-9 score less than 5.
 	
(Urgent Care Centers are not required to submit data on this measure.)
	Physician clinics must submit the following data for the depression remission at six months measure:
	▪ Patient identification methodology
	▪ Submit the following two data elements by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above):
	  ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure
	  ▪ Numerator: Number of patients meeting the targets in the measure
	▪ Number of patients meeting the exclusion criteria
	▪ Number of patients for whom a follow up six month (+/- 30 days) PHQ-9 assessment was not completed.
	▪ Calculated rate
		Depression Remission at Six Months Specifications, 2012 (February 1, 2011 – January 31, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011.
		
		Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in February 2012 and Every Year Thereafter		
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess a physician clinic's adoption and use of Health Information Technology (HIT) in their clinical practice.	Internet-based survey as updated in 2012	MN Health Information Technology (HIT) Ambulatory Clinic Survey. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
Respiratory Conditions		
Optimal asthma care composite These measures are used to assess the percent of pediatric and adult asthma patients who are receiving optimal care. Optimal care is defined as: ▪ Asthma is well controlled ▪ Patient is not at increased risk of exacerbations ▪ Patient has a current written asthma action/management plan *(Urgent Care Centers are not required to submit data on this*	Physician clinics must submit the following data for the optimal asthma care measure and for each of the three component measures: ▪ Patient identification methodology ▪ Within two separate age bands, ages 5-17 and 18-50, submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay):	Optimal Asthma Care Specifications, 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
measure.)	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample (NOTE: One sample per age band is required for this measure.) ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	healthreform
Preventive Care		
Colorectal cancer screening This measure is used to assess the percent of adult patients who are up to date with appropriate colorectal cancer screening. The screening methods include: ▪ Colonoscopy within ten years ▪ Sigmoidoscopy within five years ▪ Stool Blood Tests (gFOBT or FIT) within the measurement year	Physician clinics must submit the following data for the colorectal cancer screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay): ▪ Denominator:	Colorectal Cancer Screening Specifications, 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	healthreform
NEW: Maternity Care		
NEW: Primary c-section rate This measure is used to assess the percent of cesarean deliveries for first births. *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the maternity care primary c-section rate measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting	Maternity Care Primary C-Section Rate Specifications, 2012 (July1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
	the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	

Data Required for Reporting Beginning in Calendar Year 2013 and Every Other Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in Spring of 2013 (September 1, 2012 – November 30, 2012 Survey Period) and Every Other Year Thereafter		
Patient Experience of Care		
Patient experience of care This survey will be used to assess adult patient experience of care. MDH will require use of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) visit specific questionnaire. *(Physician clinics with less than 715 unique eligible adult patients with face-to-face visits in the three month period from September 1, 2011 – November 30, 2011 are not required to submit data on this measure. Excluded specialties include Psychiatry and Adolescent/Pediatric Medicine.)*	Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) visit specific questionnaire	Patient Experience of Care Survey Specifications. MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2013 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2013 (July 1, 2012 – June 30, 2013 Dates of Service) and Every Year Thereafter		
NEW: Maternity Care		
NEW: Early elective induction This measure is used to assess the percent of electively induced deliveries between 37 and 39 weeks gestational age. *(Urgent Care Centers are not required to submit data on this measure.)*	This measure will be required for reporting beginning in July 2013. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654. This measure is currently undergoing pilot testing.	

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2014 (2012 Dates of Service) and Every Year Thereafter		
NEW: Total Knee Replacement		
NEW: Average post-operative functional status improvement This measure is used to assess the average post-operative functional status improvement at one year post-operatively measured by the Oxford Knee Score tool. *(Urgent Care Centers are not required to submit data on this measure.)*	This measure will be required for reporting beginning in April 2014. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654. This measure is currently undergoing pilot testing.	
NEW: Average post-operative quality of life improvement This measure is used to assess the average post-operative quality of life improvement at one year post-operatively measured using the	This measure will be required for reporting beginning in April 2014. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative	

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2014 (2012 Dates of Service) and Every Year Thereafter		
EQ-5D tool. *(Urgent Care Centers are not required to submit data on this measure.)*	Rules, Chapter 4654. This measure is currently undergoing pilot testing.	

APPENDIX B
REQUIRED HOSPITAL QUALITY MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
Acute myocardial infarction (AMI) – Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart attack care: ▪ Aspirin prescribed at discharge (AMI-2) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge. ▪ Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less. ▪ Primary PCI received within 90 minutes of hospital arrival (AMI-8a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less. ▪ **NEW:** Statin prescribed at discharge (AMI-10) – This measure is used to assess the percent of acute myocardial	All hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
infarction (AMI) patients who are prescribed a statin at hospital discharge.		
Heart failure (HF) – Heart failure (HF) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart failure care: ▪ Discharge instructions (HF-1) – This measure is used to assess the percent of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen. ▪ Evaluation of LVS function (HF-2) – This measure is used to assess the percent of heart failure patients with documentation in the hospital record that left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge. ▪ ACEI or ARB for LVSD (HF-3) – This measure is used to assess the percent of heart failure patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.	All hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Pneumonia (PN) – Pneumonia (PN) process of care measures for	All hospitals must submit data for each of the	Specifications Manual for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
applicable hospital discharge dates The hospital process of care measures include the following measures related to pneumonia care: ▪ Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b) – This measure is used to assess the percent of pneumonia patients whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics. This measure focuses on the treatment provided to Emergency Department patients prior to admission orders. ▪ Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6) – This measure is used to assess the percent of immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.	hospital compare pneumonia process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Surgical care improvement project (SCIP) – Surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to surgical care improvement project: ▪ Prophylactic antibiotic received within one hour prior to surgical incision – overall rate (SCIP-Inf-1a) – This measure is used to assess the percent of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for	All hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients – overall rate (SCIP-Inf-2a) – This measure is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure). ▪ Prophylactic antibiotics discontinued within 24 hours after surgery end time – overall rate (SCIP-Inf-3a) – This measure is used to assess the percent of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after *Anesthesia End Time*. The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery. ▪ Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) – This measure is used to assess the percent of cardiac surgery patients with controlled 6 A.M. blood glucose (less than or equal to 200 mg/dL) on postoperative day one (POD 1) and postoperative day two (POD 2) with *Anesthesia End Date* being postoperative day zero (POD 0). ▪ **NEW:** Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero (SCIP-Inf-9) – This measure is used to assess the percent of surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with Surgery being day zero.		http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ **NEW:** Surgery patients with perioperative temperature management (SCIP-Inf-10) – This measure is used to assess the percent of surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8º Fahrenheit/36ºCelsius recorded within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time*. ▪ Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) – This measure is used to assess the percent of surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period. The perioperative period for the SCIP Cardiac measures is defined as the day prior to surgery through postoperative day two (POD 2) with day of surgery being day zero. If the postoperative length of stay is ≥ 2 days, the measure evaluates the administration of more than one dose of a beta-blocker: the day prior to or the day of surgery **and** on postoperative day one (POD 1) or postoperative day two (POD 2) unless reasons for not administer ▪ Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1) – This measure is used to assess the percent of surgery patients with recommended Venous Thromboembolism (VTE) prophylaxis ordered anytime from hospital arrival to 24 hours after *Anesthesia End Time*. ▪ Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2) – This measure is used to assess the percent of surgery patients who		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
received appropriate Venous Thromboembolism (VTE) prophylaxis within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time*.		
Home management plan of care given to patient/caregiver (CAC-3) – This measure is used to assess the number of pediatric asthma inpatients with documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver. The HMPC document addresses all of the following: ▪ Arrangements for follow-up care ▪ Environmental control and control of other triggers ▪ Method and timing of rescue actions ▪ Use of controllers ▪ Use of relievers	All hospitals must submit data for the home management plan of care given to patient/caregiver for pediatric asthma (CAC-3) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q11) through 06-30-11 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
NEW: Prevention immunization (PREV-IMM) – Prevention immunization (PREV-IMM) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to prevention immunization (PREV-IMM): ▪ Pneumococcal immunization (PPV23) – overall rate (PREV-IMM-1a) – This measure is used to assess acute care hospitalized inpatients 65 years of age and older AND inpatients aged between 6 and 64 years who are considered high risk and were screened for receipt of 23-valent pneumococcal polysaccharide vaccine (PPV23) and were vaccinated prior to discharge if indicated. The number	All hospitals must submit data for each of the hospital compare prevention immunization process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
captures two activities; screening and intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to PPV23, patients who were offered and declined PPV23 and patients who received PPV23 anytime in the past are captured as numerator events. ▪ Influenza immunization (PREV-IMM-2) – This measure is used to assess acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events. Influenza (flu) is an acute, contagious, viral infection of the nose, throat and lungs (respiratory illness) caused by influenza viruses. Outbreaks of seasonal influenza occur annually during late autumn and winter months although the timing and severity of outbreaks can vary substantially from year to year and community to community. Influenza activity most often peaks in February, but can peak rarely as early as November and as late as April. In order to protect as many people as possible before influenza activity increases, most flu-vaccine is administered in September through November, but vaccine is recommended to be administered throughout the influenza season as well. Because the flu vaccine usually first becomes available in September, health systems can usually meet public and patient needs for vaccination in advance of widespread influenza circulation.		http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
NEW: Mortality measures – Mortality measures for applicable hospital discharge dates The hospital measures include the following measures related to mortality: ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization (MORT-30-AMI) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of AMI. ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization (MORT-30-HF) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of HF. ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization (MORT-30-PN) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of pneumonia.	Centers for Medicare & Medicaid Services (CMS) calculates these measures using claims data and results are published on Hospital Compare. Hospitals do not need to submit additional data elements for these measures. Each hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure. This requirement applies to prospective payment system (PPS) hospitals and critical access hospitals (CAH).	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
NEW: Emergency department (ED) measures – Emergency department (ED) process of care measures for applicable hospital discharge dates The hospital emergency department (ED) process of care measures include the following measures related to hospital ED care: ▪ Median time from ED arrival to ED departure for admitted ED patients – overall rate (ED-1a) – This measure is used to assess the median time from emergency department arrival to	All hospitals must submit data for each of the emergency department (ED) quality measures. This data includes the following information: ▪ Median number of minutes	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
time of departure from the emergency room for patients admitted to the facility from the emergency department. This measure is used to assess the length of stay in the emergency room for admitted patients. ▪ Admit decision time to ED departure time for admitted patients – overall rate (ED-2a) – This measure is used to assess the median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. This measure is a subset of measure ED-1a and is used to assess the admission cycle time.		or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Outpatient acute myocardial infarction (AMI) and chest pain measures The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: ▪ Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less. ▪ Median time to transfer to another facility for acute coronary intervention – overall rate (OP-3a) – This measure is used to assess the median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary intervention for ED acute myocardial infarction (AMI) patients.	All hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: ▪ Median number of minutes **OR** ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for Hospital Outpatient Department Quality Measures, Version 5.0, encounter dates 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS); July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ Aspirin at arrival (OP-4) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) who received aspirin within 24 hours before ED arrival or prior to transfer. ▪ Median time to ECG (OP-5) – This measure is used to assess the median time from emergency department (ED) arrival to electrocardiogram (ECG) (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or chest pain patients (with Probable Cardiac Chest Pain). ▪ **NEW:** Troponin results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probably Cardiac Chest Pain*) received within 60 minutes of arrival (OP-16) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients or chest pain patients (with *Probably Cardiac Chest Pain*) with an order for troponin during the stay and having a time from ED arrival to completion of Troponin results within 60 minutes of arrival.		
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: ▪ Timing of antibiotic prophylaxis (OP-6) – This measure is used to assess the percent of surgical patients with prophylactic antibiotics initiated within one hour* prior to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics	All hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for Hospital Outpatient Department Quality Measures, Version 5.0, encounter dates 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS); July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients (OP-7) – This measure is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).		(CMS), QualityNet website http://qualitynet.org
Appropriate Care Measures (ACM)		
Acute myocardial infarction appropriate care measure (AMI-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for acute myocardial infarction (AMI). The following individual measures are included in the AMI-ACM: ▪ AMI-2: Aspirin prescribed at discharge ▪ AMI-7a: Thrombolytic within 30 minutes of hospital arrival ▪ AMI-8a: PCI within 90 minutes of hospital arrival ▪ AMI-10: Statin prescribed at discharge (AMI-10)	All hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI)/heart attack process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications for Acute Myocardial Infarction Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Heart failure appropriate care measure (HF-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for heart failure (HF). The following individual measures are included in the HF-ACM: ▪ HF-1: Discharge instructions ▪ HF-2: LVF assessment	All hospitals must submit data for each of the hospital compare heart failure (HF) process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	Specifications for Heart Failure Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ HF-3: ACEI or ARB for LVSD	targets in each of the quality measures ▪ Calculated rate	
Pneumonia appropriate care measure (PN-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for pneumonia (PN). The following individual measures are included in the PN-ACM: ▪ PN-3b: Blood cultures before antibiotic ▪ PN-6: Initial antibiotic selection for CAP in immunocompetent patient	All hospitals must submit data for each of the hospital compare pneumonia (PN) process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications for Pneumonia Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Abdominal aortic aneurysm (AAA) repair volume (IQI 4) – This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure).	All hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) – This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair.	All hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Coronary artery bypass graft (CABG) volume (IQI 5) – This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure).	All hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Coronary artery bypass graft (CABG) mortality rate (IQI 12) – This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG).	All hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) – This measure is used to assess the raw volume of provider-level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure).	All hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) – This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs).	All hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Hip fracture mortality rate (IQI 19) – This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture.	All hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Mortality for selected conditions composite (IQI 91) This composite is a weighted average of the mortality indicators for patients admitted for selected conditions and is used to assess the number of deaths for acute myocardial infarction (AMI), congestive heart failure (CHF), acute stroke, GI hemorrhage, hip fracture, and pneumonia. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions:	All hospitals must submit data for the mortality for selected conditions composite measure and for each of the mortality for selected conditions composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	AHRQ Quality Indicators: Composite Measures User Guide for the Inpatient Quality Indicators (IQI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010), Rev. May, 2011. http://qualityindicators.ahrq.go

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ Acute myocardial infarction (AMI) mortality rate (IQI 15) ▪ Congestive heart failure (CHF) mortality rate (IQI 16) ▪ Acute stroke mortality rate (IQI 17) ▪ GI Hemorrhage mortality rate (IQI 18) ▪ Hip fracture mortality rate (IQI 19) ▪ Pneumonia mortality rate (IQI 20)	targets in each of the quality measures ▪ Calculated rate	v/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_IQI_REV%205-19-11.pdf See specific mortality for selected conditions composite measure component indicators for more information. Inpatient Quality Indicators Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
Pressure ulcer (PSI 3) – This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days. *(Behavioral health only hospitals are not required to submit data on this measure.)*	All hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	All hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in each of the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) – This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure.	All hospitals must submit data for the postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	▪ Calculated rate	Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	All hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance.	All hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Patient safety for selected indicators composite (PSI 90) This composite is a weighted average of most of the patient safety indicators and is used to assess the number of potentially preventable adverse events for pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative hip fracture, postoperative hemorrhage or hematoma, postoperative physiologic and metabolic derangments, postoperative respiratory failure, postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT), postoperative sepsis, postoperative wound dehiscence, and accidental puncture or laceration. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators: ▪ Pressure ulcer (PSI 3) ▪ Iatrogenic pneumothorax (PSI 6) ▪ Central venous catheter-related bloodstream infections (PSI 7) ▪ Postoperative hip fracture (PSI 8) ▪ Postoperative hemorrhage or hematoma (PSI 9) ▪ Postoperative physiologic and metabolic derangments (PSI 10) ▪ Postoperative respiratory failure (PSI 11) ▪ Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) ▪ Postoperative sepsis (PSI 13) ▪ Postoperative wound dehiscence (PSI 14) ▪ Accidental puncture or laceration (PSI 15)	All hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	AHRQ Quality Indicators: Composite Measures User Guide for the Patient Safety Indicators (PSI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010). http://qualityindicators.ahrq.gov/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_PSI.pdf See specific patient safety for selected indicators composite measure component indicators for more information. Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Agency for Healthcare Research and Quality (AHRQ) Pediatric Patient Safety Indicators (PDI)		
Pediatric heart surgery mortality (PDI 6) – This measure is used to assess the number of in-hospital deaths in pediatric patients undergoing congenital heart disease repair *or* undergoing a non-specific heart surgery with a diagnosis of congenital heart disease present.	All hospitals must submit data for the pediatric patients undergoing surgery for congenital heart disease repair mortality (PDI 6) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric heart surgery volume (PDI 7) – This measure is used to assess the raw volume of provider-level congenital heart disease repair *or* non-specific heart surgery with a diagnosis of congenital heart disease present in pediatric patients	All hospitals must submit data for the pediatric patients undergoing surgery for congenital heart disease volume (PDI 7) quality measure. This data includes the following information: ▪ Volume	Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric patient safety for selected indicators composite (PDI 19)	All hospitals must submit data for the pediatric	AHRQ Quality Indicators:

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
This composite is a weighted average of most of the pediatric quality indicators and is used to assess the number of potentially preventable adverse events for accidental puncture or laceration, pressure ulcer, iatrogenic pneumothorax, postoperative hemorrhage or hematoma, postoperative respiratory failure, postoperative sepsis, postoperative wound dehiscence, and central venous catheter-related bloodstream infections. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators: ▪ Accidental puncture or laceration (PDI 1) ▪ Pressure ulcer (PDI 2) ▪ Iatrogenic pneumothorax (PDI 5) ▪ Postoperative hemorrhage or hematoma (PDI 8) ▪ Postoperative respiratory failure (PDI 9) ▪ Postoperative sepsis (PDI 10) ▪ Postoperative wound dehiscence (PDI 11) ▪ Central venous catheter-related bloodstream infections (PDI 12)	patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Composite Measures User Guide for the Pediatric Quality Indicators (PDI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010). http://qualityindicators.ahrq.gov/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_PDI.pdf See specific pediatric patient safety for selected indicators composite measure component indicators for more information. Pediatric Quality Indicators Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Patient Experience of Care		
Patient experience of care This measure is used to assess adult patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)*	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey	Consumer Assessment of Healthcare Providers and Systems Hospital Survey (HCAHPS), Version 6.0. Centers for Medicare & Medicaid Services (CMS); March 2011 or as updated. Measure specifications for the HCAHPS patient experience of care survey are contained in the current HCAHPS Quality Assurance Guidelines manual, which is available at the HCAHPS On-Line Web site, http://www.hcahpsonline.org. CMS maintains the HCAHPS technical specifications by updating the HCAHPS Quality Assurance Guidelines manual annually, and CMS includes detailed instructions on survey implementation, data collection, data submission and other relevant topics. As necessary, HCAHPS Bulletins are issued to provide notice of changes and updates to technical specifications in HCAHPS data collection systems.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
NEW: Minnesota Stroke Registry Indicators		
NEW: Emergency department (ED) stroke registry indicators for applicable hospital discharge dates The emergency department (ED) stroke registry indicators include the following: ▪ NIH stroke scale (NIHSS) performed in initial evaluation ▪ Door-to-imaging performed within 25 minutes or less	All hospitals must submit data for patients discharged from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill defined stroke. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Emergency Department Stroke Registry Process of Care Indicator Specifications. Minnesota Stroke Registry; August 2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
NEW: University of Minnesota Rural Health Research Center		
NEW: Critical Access Hospitals (CAHs) ONLY: Emergency department (ED) transfer communication measures – Emergency department (ED) transfer communication process of care measures for applicable hospital discharge dates *Only Critical Access Hospitals (CAHs) must submit data on these measures.* The hospital emergency department (ED) transfer communication process of care measures include the following seven subscales: ▪ Administrative communication – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that pre-transfer information was communicated to the	Critical Access Hospitals (CAHs) must submit data for each of the emergency department (ED) transfer communication quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Transfer Communication Measurement Specifications. University of Minnesota Rural Health Research Center; June 2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
receiving hospital within 60 minutes of departure. Pre-transfer information includes: nurse communication with receiving hospital and physician or practitioner communication with receiving physician or practitioner ▪ Patient information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that patient identification was communicated to the receiving hospital within 60 minutes of departure. Patient identification includes: name, address, age, gender, significant others contact information, and insurance. ▪ Vital signs – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that vital signs were communicated to the receiving hospital within 60 minutes of departure. Vital signs include: pulse, respiratory rate, blood pressure, oxygen saturation, temperature, and glascow score (trauma, cognitively altered, or neuro patients only). ▪ Medication information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that medication-related information was communicated to the receiving hospital within 60 minutes of departure. Medication information includes: medications given, allergies, and medications from home. ▪ Physician information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that physician or practitioner generated information was communicated to the receiving hospital within 60 minutes of departure. Physician information includes: history and physical (physical exam, history of current event, chronic		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
conditions) and physician or practitioner orders and plan. ▪ Nurse information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that nurse generated information was communicated to the receiving hospital within 60 minutes of departure. Nurse information includes: assessment/interventions/response, impairments, catheters, immobilizations, respiratory support, and oral limitations. ▪ Procedures and tests – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that procedures and tests were communicated to the receiving hospital within 60 minutes of departure. Procedures and tests includes: procedures and tests done and procedures and tests results sent.		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measure Required for Reporting in June 2012 and Every Year Thereafter (2011 Dates of Service)		
Vermont Oxford Network (VON)		
Late sepsis or meningitis in very low birth weight (VLBW) neonates This measure is used to assess the infection rate for inborn and outborn infants meeting certain age and weight requirements for	Hospitals with a level 3 neonatal intensive care unit (NICU) must submit data for the late sepsis or meningitis in very low birth weight (VLBW) neonates. This data includes the following	Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measure Required for Reporting in June 2012 and Every Year Thereafter (2011 Dates of Service)		
hospitals with a level 3 neonatal intensive care unit (NICU).	information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Measure specifications can be found on the Vermont Oxford Network website http://www.vtoxford.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in February 2012 and Every Year Thereafter (July 2011 – June 2012 Event Dates)		
Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures		
Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line-associated bloodstream infection (CLABSI) event by inpatient hospital unit for hospitals with a neonatal intensive care unit (NICU) and/or pediatric intensive care unit (PICU).	Hospitals with a neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in February 2012 and Every Year Thereafter (July 2011 – June 2012 Event Dates)		
	targets in the quality measure ▪ Calculated rate	Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess a hospital's adoption and use of Health Information Technology (HIT) in its clinical practice.	The information technology supplement of the American Hospital Association (AHA) annual survey and any additional Minnesota specific questions as updated in 2012	2011 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C with MN-Specific Additional Questions.

Retired Measures		
Measure Name and Description	**Data Elements**	**Specification Information**
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
Acute myocardial infarction (AMI)		
▪ Aspirin at arrival (AMI-1) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.
▪ ACEI or ARB for LVSD (AMI-3) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.
▪ Adult smoking cessation advice/counseling (AMI-4) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Beta-blocker prescribed at discharge (AMI-5) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.

Retired Measures		
Heart failure (HF)		
▪ Adult smoking cessation advice/counseling (HF-4) – This measure is used to assess the percent of heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
Pneumonia (PN)		
▪ Pneumococcal vaccination (PN-2) – This measure is used to assess the percent of pneumonia patients, age 65 and older, who were screened for pneumococcal vaccine status and were administered the vaccine prior to discharge, if indicated.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Adult smoking cessation advice/counseling (PN-4) – This measure is used to assess the percent of pneumonia patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Initial antibiotic received within 6 hours of hospital arrival (PN-5c) – This measure is used to assess the percent of pneumonia patients who receive their first dose of antibiotics within 6 hours after arrival at the hospital.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Influenza vaccination (PN-7) – This measure is used to assess the percent of pneumonia patients age 50 years and older, hospitalized during October, November, December, January, February, or March who were screened for influenza vaccine	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.

Retired Measures		
status and were vaccinated prior to discharge, if indicated.		
Surgical care improvement project (SCIP) ▪ Surgery patients with appropriate hair removal (SCIP-Inf-6) – This measure is used to assess the percent of surgery patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered appropriate. Shaving is considered inappropriate.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.

APPENDIX C
REQUIRED AMBULATORY SURGICAL CENTER MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
Prophylactic intravenous (IV) antibiotic timing – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who were administered antibiotics for prevention of surgical site infection on time	Ambulatory surgical centers must submit data for the prophylactic intravenous (IV) antibiotic timing quality measure. This data includes the following information: ▪ Patient identification methodology ▪ Submit the following three data elements: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Hospital transfer/admission – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who are transferred or admitted to a hospital upon discharge from the ASC.	Ambulatory surgical centers must submit data for the hospital transfer/admission quality measure. This data includes the following information: ▪ Patient identification methodology	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
	▪ Submit the following two data elements by the American Society of Anesthesiologists (ASA) Physical Status classification system categories (i.e., ASA Physical Status 1 – ASA Physical Status 3): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Appropriate surgical site hair removal – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who have appropriate surgical site hair removal.	Ambulatory surgical centers must submit data for the appropriate surgical site hair removal quality measure. This data includes the following information: ▪ Patient identification methodology ▪ Submit the following three data elements: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
	on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	http://www.health.state.mn.us/healthreform

APPENDIX D
OTHER STANDARDIZED QUALITY MEASURES

Measure Name	Measure Elements	Specification Information
Unlimited Availability		
Healthcare Effectiveness Data and Information Set (HEDIS)	All Healthcare Effectiveness Data and Information Set (HEDIS) measures as of HEDIS 2011, or as updated, that are applicable to physician clinics, are included in the standardized set of quality measures.	Healthcare Effectiveness Data and Information Set (HEDIS) 2011 Volume 2: Technical Specifications. National Committee for Quality Assurance (NCQA); 2010 or as updated.
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of August 1, 2011, or as updated, that are applicable to physician clinics and hospitals, are included in the standardized set of quality measures, excluding those requiring use of proprietary databases or registries.	More information about these measures can be found on the National Quality Forum (NQF), website http://qualityforum.org

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for Two Years (2011 Dates of Service Through 2012 Dates of Service)		
Pediatric asthma	For patients, ages 5 to 19 years: ▪ At the last asthma visit, is the asthma severity level (intermittent or persistent) documented? ▪ If it is documented that the patient has persistent asthma, is the patient on an anti-inflammatory medication? ▪ If the patient is a smoker or exposed to second hand smoke, is advice regarding smoking cessation documented in the last year?	Clinical Review: Measure Specifications for Pediatric Asthma. Medica; Pediatric Asthma; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

	▪ If the patient is a smoker, or exposed to second hand smoke, is advice regarding smoking cessation documented at the last visit? ▪ Is the child's environment tobacco smoke free? ▪ Is there evidence in the medical records that the patient received a written Asthma Action Plan? ▪ Unless contraindicated, is there evidence in the medical record that the patient has received an influenza vaccine within the past year?	

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for One Year (2011 Dates of Service)		
Adult depression	For adults, ages 19 years and older: ▪ At the time of initial diagnosis in the past year, was there documentation of at least 5 of the symptoms of depression, or that the patient met the criteria for depression using a standardized depression diagnosing tool? ▪ At the time of the initial diagnosis in the past year, is there documentation that the patient was assessed for alcohol consumption? ▪ If the patient was at the clinic for a primary care visit more than 6 weeks after the initial diagnosis, is there documentation of ongoing assessment of their depression status? ▪ Was the patient's depression status reassessed using the PHQ-9 tool at a follow up visit within 6 months after diagnosis? ▪ Was the PHQ-9 depression diagnostic tool used for the initial depression diagnosis?	Clinical Review: Measure Specifications for Adult Depression. Medica; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

APPENDIX E
SUBMISSION SPECIFICATIONS

I. Submission Requirements for Physician Clinics

1. **Registration.** Each physician clinic, regardless of the number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic, must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning January 1, 2012 and no later than February 10, 2012 and no later than February 10 of each subsequent year, and must supply data elements, including the following:

    a. **Physician clinic information:** Name, street address, unique clinic national provider identifier (NPI) regardless of the physician clinic's number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic (i.e. satellite clinics);

    b. **Contact information for individual(s) responsible for submitting data:** Company, name, title, mailing address, telephone number, fax number, e-mail address;

    c. **Contact information for physician clinic general contact:** Name, title, mailing address, telephone number, fax number, e-mail address;

    d. **Clinical staff information for the previous calendar year:** Name, unique national provider identifier (NPI), full-time equivalent (FTE) status, license number, board certifications for each clinical staff that have provided health care services at the physician clinic during the previous calendar year;

    e. **Description of health care services provided by the physician clinic.**

    f. **Medical group affiliation.**

    NOTE: If multiple physician clinic locations meet the criteria in MN Rules 4654.0200 subp. 13 and choose to submit data as a single entity, each individual physician clinic location must still register and indicate under which entity their data will be submitted.

2. **Data Submission.**

    a. **Measures for which physician clinics may submit on their full patient population or a random sample in 2012. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place for the prior full measurement period are required to submit data on their full patient population.)**

    Optimal diabetes care (ODC) composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and by presence / absence of ischemic vascular disease (IVD) co-morbidity to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type and IVD co-morbidity, number of patients meeting the exclusion

criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type or by IVD co-morbidity. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2012 and no later than February 15, 2012 and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since January 1, 2010 are required to submit data on their full patient population for this measure.)

Optimal vascular care (OVC) composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and by presence / absence of diabetes co-morbidity to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type and by diabetes co-morbidity, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type or by diabetes co-morbidity. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2012 and no later than February 15, 2012 and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since January 1, 2010 are required to submit data on their full patient population for this measure.)

Optimal asthma care composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee. For this measure, this includes identifying the patients in two separate age bands, ages 5-17 and ages 18-50. If the physician clinic submits a sample, there must be one sample per age band. Within these two age bands, data on the number of patients receiving the applicable health care services must be allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay). Specifically, this includes patient identification methodology, separation of the data by age bands, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since July 1, 2010 are required to submit data on their full patient population for this measure.)

Colorectal cancer screening. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since July 1, 2010 are required to submit data on their full patient population for this measure.)

i. **Data submission requirements.** A physician clinic may satisfy the data submission requirement for these quality measures by completing the following steps:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Develop a list of the eligible patients for each measure using a practice management, billing system, or electronic medical record.

2. **Data collection: total population versus sample.** Identification of the population of patients eligible for the denominator for each measure is accomplished via a query of a practice management system or an electronic medical record. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Physician clinics may choose one of the following options:

a. Full patient population. Physician clinics with electronic medical records in place for the prior full measurement period are required to submit data on their full patient population for each measure. Physician clinics without electronic medical records in place for the prior full measurement period are encouraged to submit data using their full patient population for each measure, but may use a random sampling methodology, as described below.

b. Random sampling methodology. Physician clinics may submit data on a random sample of relevant patients in 2012. At a minimum, physician clinics must select 60 patients for

the random sample population and must oversample by at least 20 patients. If a physician clinic's total population for a particular measure is less than 60, the physician clinic must submit data using their full patient population for that measure. Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place for the prior full measurement period will be expected to submit data on a full population basis. (NOTE: For the optimal asthma measure, there must be one sample per age band, one for ages 5-17 and one for ages 18-50.)

3. **Data submission template**. Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.
4. **Data file upload.** Submit data electronically to the commissioner or the commissioner's designee.
5. **Data validation.** Physician clinics must maintain documentation for the data described in Appendix A, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

b. Measures for which physician clinics may only submit data on their full patient population in 2012.

Depression remission at six months. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee. For this measure, the data elements must be submitted by three bands of initial PHQ9 scores (10-14; 15-19; 20 and above). The number of patients for whom a follow up six month (+/- 30 days) PHQ9 assessment was not completed is a required data element as well. Specifically the required data includes, patient identification methodology, numerator and denominator separated by three bands of initial PHQ9 scores, number of patients who did not get a second PHQ9 assessment, number of patients meeting the exclusion criteria, and calculated rate. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning February 7, 2012 and no later than February 25, 2012.

Primary c-section rate. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. A physician clinic may work with a single subcontractor to submit the required data on their

behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year.

i. **Data submission requirements.** A physician clinic may satisfy the data submission requirement for these quality measures by completing the following steps:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Develop a list of the eligible patients for each measure using a practice management, billing system, or electronic medical record.
2. **Data collection: Total population.** Identification of the population of patients eligible for the denominator for each measure is accomplished via a query of a practice management system or an electronic medical record. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. For this measure physician clinics must submit data using their full patient population.
3. **Data submission template**. Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.
4. **Data file upload.** Submit data electronically to the commissioner or the commissioner's designee.
5. **Data validation.** Physician clinics must maintain documentation for the data described in Appendix A, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

3. **Health information technology (HIT) survey.** Each physician clinic must complete the internet-based survey available annually from the commissioner or commissioner's designee beginning February 15, 2012 and no later than March 15, 2012 and beginning February 15 and no later than March 15 of each subsequent year.
4. **Patient experience of care survey.** Each physician clinic must use a vendor certified by CMS.[1] Each physician clinic must either select a CMS-certified vendor of its choice or use the services of a centralized vendor coordinated by the commissioner or the commissioner's designee. Survey period will include patients seen September 1, 2012 – November 30, 2012.

[1] CMS does not certify vendors to administer CG-CAHPS for physician clinics. For purposes of fulfilling state requirements under Chapter 4654, physician clinics must use a vendor certified by CMS to administer HCAHPS or MA and PDP CAHPS.

II. Submission Requirements for Hospitals

1. **Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Measures.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures. There are two ways hospitals may satisfy this requirement:

   a. **Submission to the Centers for Medicare & Medicaid Services (CMS).** If a hospital normally submits data for all cases for these quality measures to the Centers for Medicare & Medicaid Services (CMS), using the Centers for Medicare & Medicaid Services' (CMS) existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure; or

   b. **Submission directly to commissioner or commissioner's designee.** If a hospital does not submit data for these quality measures to the Centers for Medicare & Medicaid Services (CMS), the hospital must submit data to the commissioner or the commissioner's designee according to the following schedule:

Inpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

Outpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 1, 2012
Fourth Quarter, 2011: October 1 – December 31	May 1, 2012
First Quarter, 2012: January 1 – March 31	August 1, 2012
Second Quarter, 2012: April 1 – June 30	November 1, 2012

i. Data collection and analysis.

1. Hospitals must use the CMS Abstraction & Reporting Tool (CART), available from the Centers for Medicare & Medicaid Services (CMS), for the collection and analysis of the data required to calculate each measure.

2. Use the measurement specifications referenced in Appendix B to determine whether each patient is eligible for inclusion in the measurement calculation.

ii. Data validation. At their own expense, hospitals must have their data validated by a third-party vendor using protocols and standards consistent with those of the Centers for Medicare & Medicaid Services (CMS) to verify that the data is consistent and reproducible.

iii. Data submission. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

2. **Data Submission for Appropriate Care Measures (ACM).** Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

There are two ways hospitals may satisfy this requirement.

a. **Each hospital may authorize a single organization to complete the following steps and submit the data on their behalf:**

i. Signs an authorization form allowing Stratis Health to release summary level ACM data, calculated from data in the CMS national data repository, to MHA for publication on the MHA website, Minnesota Hospital Quality Report.

b. **Each hospital may perform the following steps itself:**

i. Data collection and analysis. Identify the patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria. The ACM is a pass/fail measure at the individual patient level that asks whether eligible patients have received ALL of the appropriate care for the condition they are being treated for. A patient is included if the patient meets denominator criteria for at least one of the measures in a topic. These topics include heart failure, acute myocardial infarction, and pneumonia. Within each topic, a patient must meet numerator criteria for each measure in which the patient meets denominator criteria to be considered as having appropriate care (Pass).

ii. Data submission. Submit data electronically to the commissioner or the commissioner's designee.

3. **Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	January 28, 2012
Fourth Quarter, 2011: October 1 – December 31	April 29, 2012
First Quarter, 2012: January 1 – March 31	July 23, 2012
Second Quarter, 2012: April 1 – June 30	October 22, 2012

There are two ways hospitals may satisfy this requirement.

a. **Each hospital may authorize a single organization to complete the following steps and submit the data on their behalf:**

   i. Apply Version 4.3, or the most recent version of the Quality Indicator software, available from the Agency for Healthcare Research and Quality's (AHRQ), to the hospital's discharge data. A hospital must participate in verifying the results of the analysis as needed.

   ii. Validate the data.

      1. In the event data validation procedures show that data is inaccurate, hospitals must correct the inaccurate information and resubmit corrected data. Resubmitted data must be verified for accuracy.

      2. The results of the analysis using the Quality Indicator software for each hospital must be verified for accuracy by each hospital prior to submission.

   iii. Submit the data to the commissioner or the commissioner's designee.

b. **Each hospital may perform the following steps itself:**

   i. Apply Version 4.3, or the most recent version of the Quality Indicator software, available from the Agency for Healthcare Research and Quality's (AHRQ), to its discharge data.

   ii. Validate the data submission through a third-party vendor.

   iii. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

4. **Data Submission for Vermont Oxford Network (VON).** Each hospital with a level 3 neonatal intensive care unit (NICU) must submit the data required to calculate the applicable quality measure, as described in Appendix B, to VON.

   a. Each hospital with a level 3 NICU must submit applicable data on the specified patients to VON, for measure calculation and inclusion in VON's annual report to the hospital, according to the following VON data submission schedule:

Discharge Dates	Data Submission Deadline
All 2011 Dates of Service	June 30, 2012

b. Each hospital with a level 3 NICU must submit summary level results electronically for the previous calendar year to the commissioner or the commissioner's designee by October 31, 2012 and every year thereafter.

5. **Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures.** Each hospital with a neonatal and/or pediatric intensive care unit must submit the data described in Appendix B required to calculate the applicable quality measure. There are two ways hospitals with a neonatal and/or pediatric intensive care unit may satisfy this requirement:

   a. Submission to the Centers for Medicare & Medicaid Services (CMS). If a hospital normally submits data for all cases for these quality measures to the Centers for Medicare & Medicaid Services (CMS), using the Centers for Medicare & Medicaid Services' (CMS) existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure; or

   b. Submission directly to commissioner or commissioner's designee. If a hospital does not submit data for these quality measures to the Centers for Medicare & Medicaid Services (CMS), the hospital must submit data to the commissioner or the commissioner's designee according to the following schedule:

Event Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

   i. Data collection and analysis.

      1. Hospitals must submit data to the Centers for Disease Control and prevention (CDC) through the National Healthcare Safety Network (NHSN) according to NHSN definitions for each intensive care unit for the collection and analysis of the data required to calculate each measure.

      2. Use the measurement specifications referenced in Appendix B to determine whether each patient is eligible for inclusion in the measurement calculation.

   ii. Data validation. At their own expense, hospitals must have their data validated by a third-party vendor using protocols and standards

consistent with those of the Centers for Medicare & Medicaid Services (CMS) to verify that the data is consistent and reproducible.

iii. Data submission. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

6. **Data Submission for Minnesota Stroke Registry Indicators.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality indicators according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

There are three ways hospitals may satisfy this requirement.

a. **Participation in the Minnesota Stroke Registry (MSR).** If a hospital normally participates in the Minnesota Stroke Registry (MSR) and submits data for all cases to the Minnesota Stroke Registry (MSR), using the Minnesota Stroke Registry Tool (MSRT), existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also authorizes the data to be calculated and submitted to the commissioner or the commissioner's designee.

b. **Data submission to a third-party vendor.** If a hospital normally submits data used to calculate these quality measures to a third-party vendor and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also authorizes the data to be shared with the Minnesota Stroke Registry (MSR) and authorizes the Minnesota Stroke Registry Tool (MSRT) to calculate and submit the data to the commissioner or the commissioner's designee.

c. **Each hospital may perform the following steps itself:**

i. Identify the patients meeting the criteria for inclusion in the indicator. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria.

ii. Submit data electronically to the commissioner or the commissioner's designee using the Minnesota Stroke Registry Tool (MSRT).

7. **Data Submission for Emergency Department (ED) Transfer Communication Measures.** Each critical access hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline

Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

a. Data collection and analysis. Identify the patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria.

b. Data submission. Submit summary level data electronically to the commissioner or the commissioner's designee.

8. **Health information technology (HIT) survey.** Each hospital must complete the survey available annually from the commissioner or commissioner's designee in calendar year 2012 and each subsequent year.

9. **Patient experience of care survey.** Each hospital must complete the HCAHPS survey using a CMS-certified vendor.

III. Submission Requirements for Ambulatory Surgical Centers

1. **Registration.** Each ambulatory surgical center must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning March 1, 2012 and no later than April 1, 2012 and no later than April 1 of each subsequent year; and must supply data elements, including the following:
   a. **Ambulatory Surgical Center information:** Name, street address, ambulatory surgical center national provider identifier (NPI);
   b. **Contact information for individual(s) responsible for submitting data:** Company, name, title, mailing address, telephone number, fax number, e-mail address;
   c. **Contact information for ambulatory surgical center general contact:** Name, title, mailing address, telephone number, fax number, e-mail address;
   d. **Clinical staff information for the previous calendar year:** Name, national provider identifier (NPI), board certifications for all clinical staff that have provided health care services at the ambulatory surgical center during the previous calendar year;
   f. **Medical group affiliation if applicable.**

2. **Data Submission.** Each ambulatory surgical center must submit the data required to calculate the applicable quality measures, as described in Appendix C, to the commissioner or the commissioner's designee. An ambulatory surgical center may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. Beginning with 2012 data submission deadlines, each ASC must allocate the data required to calculate the applicable quality measures by the American Society of Anesthesiologists (ASA) Physical Status classification when the commissioner or the commissioner's designee determines the results must be risk adjusted. In 2012, based on current measures, this would apply to the hospital transfer/admission measure.
   a. **Prophylactic intravenous (IV) antibiotic timing and Appropriate surgical site hair removal.**
      i. **Data submission requirements.** Each ambulatory surgical center may satisfy the data submission requirements for these quality measures by completing the following steps:
         1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix C to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list.
         2. **Data collection: total population versus sample.** Beginning in 2012, ambulatory surgical centers with an electronic medical record in place for the prior full measurement period will be expected to submit data on a full population basis. Ambulatory surgical centers without an electronic medical record in place for the prior full

measurement period may submit data on a random sample of relevant patients in 2012. Ambulatory surgical centers with fewer than 60 relevant patients for each measure must submit data on all relevant patients.

3. **Data submission template.** Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.
4. **Data file upload. Submit data electronically to the commissioner or the commissioner's designee.**
5. **Data validation.** Ambulatory surgical centers must maintain documentation for the data described in Appendix C including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template for purposes of data validation.

b. Hospital transfer/admission.

For this measure, the data elements must be submitted by the American Society of Anesthesiologists (ASA) Physical Status classification categories (i.e., ASA Physical Status 1 – ASA Physical Status 3) to the commissioner or commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by ASA Physical Status, number of patients meeting the exclusion criteria, and calculated rate.

i. Data submission requirements. Each ambulatory surgical center may satisfy the data submission requirements for these quality measures by completing the following:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix C to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list.
2. **Data collection: total population versus sample.** Beginning in 2012, ambulatory surgical centers with an electronic medical record in place for the prior full measurement period will be expected to submit data on a full population basis. Ambulatory surgical centers without an electronic medical record in place for the prior full measurement period may submit data on a random sample of relevant patients in 2012. Ambulatory surgical centers with fewer than 60 relevant patients for each measure must submit data on all relevant patients.
3. **Data submission template.** Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either

extracted from an electronic medical record system or abstracted through medical record review.

4. **Data file upload. Submit data electronically to the commissioner or the commissioner's designee.**
5. **Data validation.** Ambulatory surgical centers must maintain documentation for the data described in Appendix C including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template for purposes of data validation.

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Appendix 15 – Health Care Delivery Systems Demonstration Overview

(Appendix not available at this time)

Appendix 16 – Health Plan Appendix

Appendix 16

Total Cost of Care Initiatives in Minnesota's Non-Profit HMOs

Minnesota's health plans and their provider partners are actively engaged in total cost of care (TCOC) and ACO initiatives across the state. A key advantage of these arrangements is that they apply not just to the commercially-covered enrollee, but also may include state public programs enrollees. As demonstrated below, Minnesota's health plans are implementing payment reform models that are working in the marketplace and showing tangible results:

 Blue Cross and Blue Shield of Minnesota, in partnership with key provider partners across Minnesota, has developed a new relationship model which aligns incentives with the goal of achieving the triple aim of improving quality, controlling costs and improving member engagement. Blue Cross currently has 10 such models with providers across the state. These aligned incentive providers cover approximately 35 percent of the Blue Cross volume in Minnesota and 65 percent within the Twin Cities metropolitan area.

This new model rewards providers that achieve or improve outcomes for key quality metrics (e.g., optimal diabetic care, optimal vascular care, reducing preventable admissions and readmissions) and control health care costs below historical trends. Blue Cross meets regularly with partner providers and delivers actionable data that providers can use to help redesign care models and processes to improve quality and costs. These new care models and processes not only impact and benefit Blue Cross commercial members but also any patient who receives care at any provider that has redesigned their care model because of this program.
Overall, the first year results are promising. A majority of provider partners have controlled costs at a level below targets while also making measurable improvements in key quality indicators.

 As an integrated care delivery system focused on the Triple Aim, **HealthPartners** has been at the forefront of payment and delivery system innovation for many years. The National Quality Forum (NQF) endorses the HealthPartners Total Cost of Care and Total Resource Use measurement approach. The number of health care providers with Total Cost of Care contracts with HealthPartners continues to grow. In 2012, more than 25 providers have Total Cost of Care contracts, including several large care systems in Greater Minnesota. More than 80 percent of HealthPartners members will receive care this year under Total Cost of Care contracts, a number that is expected to grow in 2013.

In addition, this approach yields measurable results. HealthPartners and 14 care delivery systems in Minnesota and the Upper Midwest combined to save nearly $20 million in health care costs through shared savings contracts that reward providers who provide quality care while reducing overall cost. Provider groups with a Total Cost of Care contract with HealthPartners outperformed provider groups with a traditional fee-for-service arrangement while also increasing quality. Overall medical trend – the amount health care costs increase from one year to the next – was one percentage point lower for groups covered by Total Cost of Care contracts than for those covered by traditional contracts.

In aligning payment with health outcomes, HealthPartners supports care systems through the use of claims information and health informatics. That data helps determine areas in which each care delivery system used more resources than other systems. In turn, many providers were able to improve patient care while reducing costs.

 Medica has collaborated with providers for the last five years in innovative ways to reward them for providing the right health services at the right time and place to best meet members' needs. These collaborations started with clinic based chronic care management (CBCCM) and medical home pilot programs, and have since evolved to include TCOC arrangements and ACOs.

Currently, Medica has TCOC arrangements with approximately a dozen health systems in Minnesota, and 70 percent of Medica's membership in the Twin Cities area receives their care from a provider under a TCOC payment arrangement. Medica's TCOC arrangements include various quality and efficiency measures agreed to in collaboration with its provider partners based on both parties' abilities and goals. Under these agreements, health systems have agreed to manage the "total cost of care" for Medica members attributed to their primary care providers. TCOC arrangements may use at risk performance pools, differentials in future contract rates, or benchmark total cost measures to achieve the shared goals of improved health and lower costs.
Most recently Medica has entered into ACO arrangements with certain providers. Under these arrangements, Medica members select a network and the network takes financial risk for all members who have chosen the network's ACO product. Some ACO arrangements include unique coordinated customer service and health management features so members have one point of reference for care and coverage questions. Like Medica's TCOC arrangements, ACO agreements are unique to each provider system based on capabilities and goals.

 UCare and Lakewood Health System in rural north central Minnesota worked together to create a new, patient-centered ACO model which integrates a central

primary care focus, coordinated care and specialized care. UCare and Lakewood designed a care management payment and a risk/gain share arrangement to better serve Medicare, Medicaid, and dual-eligible members in this rural region. Key findings include:

o The number of clinic visits trended downward by about 42 percent.

o Total cost of care per clinic visit, per enrollee, decreased by 37 percent. This includes Lakewood system visits and out-of-system referrals.

o The average number of inpatient admissions was reduced by 18 percent.

o The average medication costs per enrollee trended downward by 38 percent.

 PreferredOne has been using the TCOC methodology for provider reimbursement for three years. PreferredOne is working with systems to design the process so it fits with what they are doing with CMS and the changes they feel necessary to optimize the program for improved management and care to members. At this time PreferredOne has approximately 32 percent of its membership being cared for under a TCOC type contract.