



State Levers to Advance Accountable Communities for Health

Minnesota State Profile

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Overview

Minnesota's Accountable Communities for Health (ACH) initiative seeks to improve the overall health of communities across the state through the delivery of person-centered, coordinated care that addresses the clinical and social needs of a defined population. To accomplish this goal, ACHs are responsible for fostering community-clinical linkages that improve patient care and developing a population-based prevention plan specific to their communities. The ACH model is a core component of the

three-year State Innovation Model (SIM) Testing grant Minnesota received in 2013. Under SIM, Minnesota is testing the effectiveness of its Accountable Health Model in improving health, providing better care, and reducing health care costs for Minnesota residents. The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) jointly lead the state's SIM initiative with support from the governor's office. Of the \$45 million Minnesota received to implement the Accountable Health Model under SIM, the state has allocated approximately \$5.6 million to support 15 ACH projects that currently engage 180 clinical and social service providers.

The ACH program builds on the success of multiple payment and delivery system reform initiatives in Minnesota including health care homes, community care teams, and accountable care organizations (ACOs). Community care teams, locally based teams responsible for coordinating multiple health and social services for patients, are considered to be the foundation for ACHs. The three original community care teams Minnesota implemented in 2011 were the first communities to receive ACH funding in late 2014. Minnesota's ACOs are also closely aligned with the ACH initiative, as the state requires each ACH to partner with an ACO. Through this partnership, the state is assessing the ability of ACHs to improve health outcomes and reduce costs for an ACO by coordinating support systems and integrating health-related services for its patients.

Governance

ACHs have developed diverse governance bodies corresponding with the state's intent for the ACH decision-making entity to reflect key partners and its target population. Rather than prescribing a specific governance structure for ACHs, the state has established a set of broad guidelines. ACH lead-

Minnesota ACH Fast Facts

Number of ACH demonstration sites: 15

Funding allocated to each ACH: \$370,000 total for 2 years

Implementation Dates:
February 2015 – December 2016

ership must be locally based and include an array of providers and community partners in addition to members of the community and population served. Minnesota required ACH leadership structures to be in place prior to applying for funding and charged leadership with the responsibilities of identifying ACH priorities and developing coordinated strategies to address the needs of ACH target populations.

Beyond requirements for ACHs to partner with an ACO, it is largely at the discretion of the ACH to select appropriate partners that meet the health and social needs of the target population. Examples of additional ACH partners include primary and acute care providers, behavioral health providers, local public health departments, long-term care services, community services organizations, and social services such as employment, food, and housing.

Targeted Populations/Conditions

Minnesota's ACH model is fundamentally driven at the local level. Priority conditions are identified by the state, but communities are responsible for proposing ACH target populations with significant health and social needs. ACHs can be designed to serve a population in either a defined geographic area or a specific community with an identified need. For example, one of Minnesota's ACHs serves Medicaid beneficiaries and uninsured, low-income residents in three specific counties while another targets patients with developmental and intellectual disabilities served by a particular ACO. As such, ACHs may not reach the entire state but can also have overlapping geographic boundaries.

Financing Model

After a competitive application process, Minnesota disbursed grants in the amount of \$370,000 to 12 ACH applicants in addition to 3 pre-existing community care teams, accounting for 15 total ACHs. The grant money is intended to support the costs of developing ACH infrastructure, organizing leadership team activities, and coordinating care across community partners. Start-up grant funding expires at the conclusion of the SIM testing grant period, in December 2016. ACHs are responsible for developing sustainability plans that can incorporate funding from a variety of federal, state, and local resources.

State Resources offered to ACHs

In addition to initial grant funding, Minnesota offers training and technical assistance to support certain ACH activities including sustainability planning, leadership development, care coordination, and establishing community-clinical linkages. MDH and DHS are facilitating a mandatory ACH learning community to disseminate best practices and supply expert resources. Finally, the state anticipates many medical service providers partnering with ACHs will be able to contribute data on quality measures available through the Statewide Quality Reporting and Measurement System in order to guide quality improvement efforts.

Next Steps

To ensure ACH activities endure after SIM, ACHs are developing sustainability plans that align with Minnesota's Accountable Health Model. ACHs are working to identify viable financing mechanisms and measurement strategies to assess ACH progress. The state is supporting ACHs in these endeavors and encouraging ACHs to consider aligning with emerging opportunities such as the Accountable Health Community initiative from the Center for Medicare and Medicaid Innovation or the Community Transformation Grant program from the Centers for Disease Control and Prevention.