Recommendations	Total Points	Total Votes	Max. Points	% Max Points Received
Make technical updates and clarifications to Minnesota's Health Records Act to leave a patient's ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.	19	7	21	90%
Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing in appropriate use.	15	7	21	71%
Conduct a broad study on the appropriate future structure, legal/regulatory framework, financing, and governance for HIE in Minnesota, building on lessons from other states and countries. The study will build on lessons learned in Minnesota as well as other states and countries. Study questions will include, but not be limited to: Whether Minnesota should continue to use a market-based approach to HIE, or develop a single statewide HIE entity; Whether additional 'shared services,' such as consent management, should be developed; The appropriate funding source(s), and needed level of funding, to support core HIE transactions and shared services for all health and health care provider statewide; and Whether Minnesota's current legal/regulatory framework for HIE supports or hinders secure HIE that is aligned with patient preferences.	17	7	21	81%
Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Pilots and programs will not be significantly expanded until an evaluation on cost benefits is conducted.	16	7	21	76%
To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.	15	6	18	83%

Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches: Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels; Expansion of value-based purchasing within current system; Publicly-financed, privately-delivered universal health care system. The study would additionally examine the stability and sustainability of the health care system under the approach and identify any data or information needed to design and implement the system.	14	7	21	67%
Incorporate enhancements, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with significant expansion across the full population only following robust evaluation of program's impact on Triple Aim.	12	6	18	67%
Encourage or incentivize partnerships and care coordination activities with broad range of community organizations within care coordination models.	18	7	21	86%
Fund innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.	19	7	21	90%
Encourage or incentivize participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.	18	7	21	86%
Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider's previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.	12	7	21	57%

Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions, plus appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.	12	7	21	57%
For participants not attributed to an ACO (such as IHP program), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.	16	7	21	76%
For participants attributed to an ACO (including risk-taking IHP program), provide a prospective "pre-payment" of a portion of their anticipated TCOC savings.	13	7	21	62%
Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.	12	6	18	67%
Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social/non-medical complexity, and enhance payment rates to incorporate costs associated with care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.	16	7	21	76%
Allow patients to choose a provider during the enrollment process and change their primary provider outside of enrollment. Give providers data about who enrolled with them and so they have the opportunity to proactively engage with those enrollees. Use consistent method across payers.	17	7	21	81%
Attribute or assign patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery), with back-end reconciliation.	13	7	21	62%