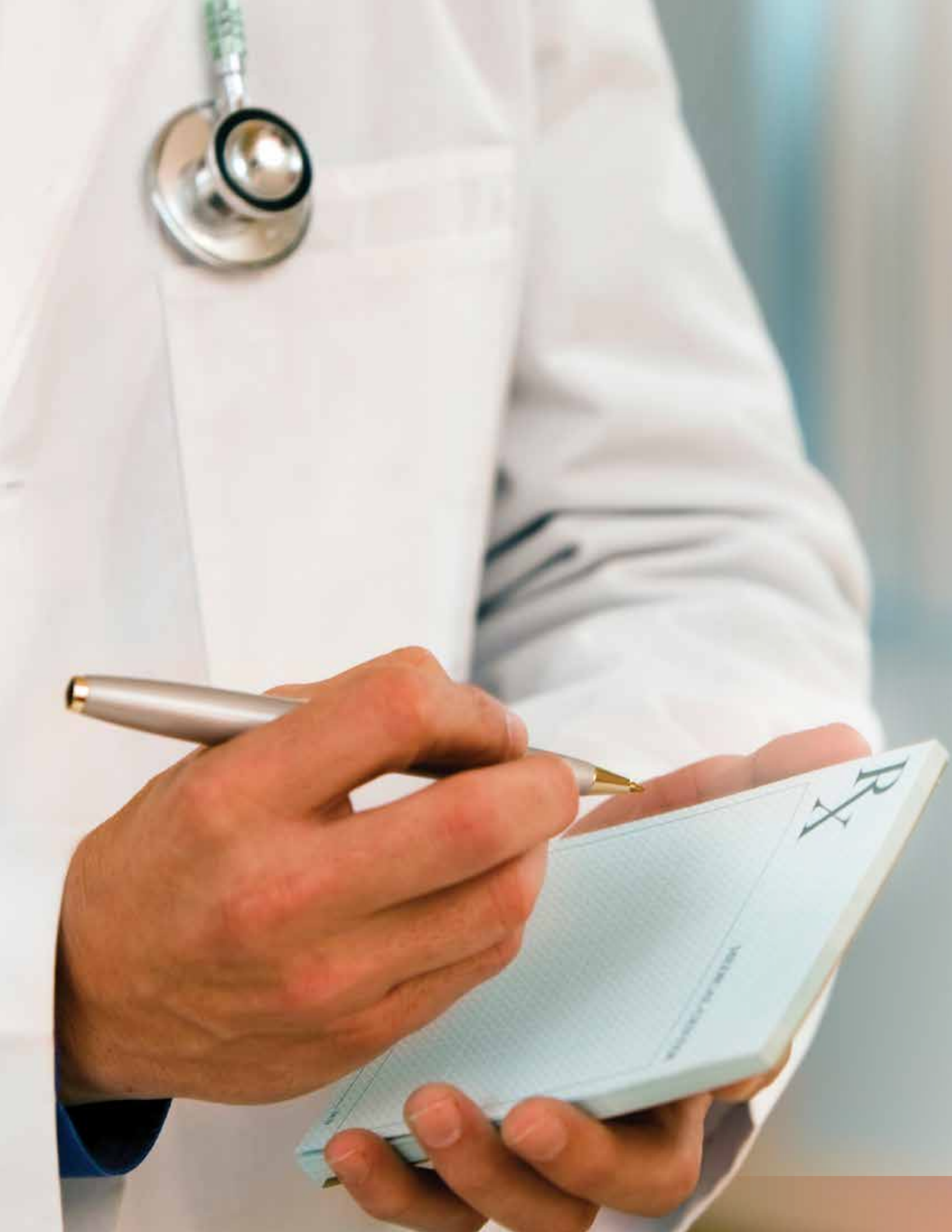
MINNESOTA BUSINESS PARTNERSHIP

Minnesota's Health Care Performance Scorecard:

Putting the state's health care system in national perspective

January, 2015



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PREFACE

This is a critical time in the evolution of Minnesota's health care system. A national leader in health care delivery as well as overall population health, Minnesota is undertaking an ambitious set of reforms and experimenting with innovative payment and delivery models that will impact every aspect of the health care system and the lives of Minnesotans in every corner of the state.

These reforms offer promise but also introduce uncertainty. Properly managed and executed, they can help establish a sustainable, market-based, patient-centered system, with improved quality and lower costs. If not managed correctly, however, they might create conditions that suppress innovation and drive costs even higher.

In this period of rapid change and experimentation, it is essential to have a clear view of how the system is performing and to understand what must be done to make the most of the opportunity before us.

To achieve these goals, the Minnesota Business Partnership (MBP) has developed the Health Care Performance Scorecard described in this report. The purpose of the report is to provide a comprehensive but accessible fact base on the system's performance to inform consumers, employers, decision makers and opinion leaders. We highlight key challenges and areas of opportunity, and offer a few practical recommendations to improve the state's health care system.

This research has been sponsored by the Minnesota Business Partnership as part of the its health care reform program. We are enormously grateful to a number of individuals and organizations that have supported and contributed to this work. We are particularly indebted to Jim Chase of Minnesota Community Measurement, Donna Zimmerman of HealthPartners, and Paul Mattessich of the Wilder Foundation for their guidance and support.

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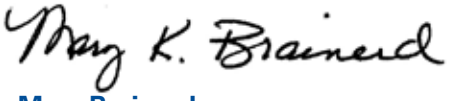

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EXECUTIVE SUMMARY

Minnesota's health care system is in a period of transition. Long recognized as a national leader in health care, Minnesota is home to a number of world-class medical and research institutions, and consistently ranks among the best-performing states in terms of coverage, access to high-quality care, and overall health of the population. However, the state also faces many of the same challenges straining health care systems nationwide. The aging population, increasing prevalence of chronic conditions, and unsustainable growth in the cost of care pose challenges that will require meaningful, systemwide reform in the way we provide and pay for care, as well as the ways in which we manage the health of the population. A number of ambitious programs are currently being implemented to address these challenges as part of state and federal health care reform laws, as well as through private and social sector initiatives. These reforms are unprecedented in Minnesota's history in their scope, scale, and complexity, and will impact every part of the state's health care system in the coming years.

In the midst of this rapid change, it is critically important to understand how the health care system is performing: Where is the state doing well, where is it falling behind, how are we proceeding with planned reforms, and how well are they working? This report and the Minnesota Health Care Performance Scorecard on which it is based are intended to provide a factual foundation with which to address these questions. The goal of this work is to establish a comprehensive yet concise assessment of how the state's health care system is performing relative to those of other states so that we might better identify strengths to build upon, as well as gaps and opportunities for improvement. Drawing upon this research, the report makes a number of practical recommendations for how the state and the business community can work together to support and improve the health care system in this period of dynamic change.

Overview of findings

The Performance Scorecard evaluates Minnesota's health care system relative to those of other states and the nation as a whole along five dimensions of performance:

1. **Coverage and access**, including health care coverage, system capacity, and access to health care services
2. **Population health**, including health care risk factors, prevalence and incidence of illness and injury, and health outcomes
3. **Health care delivery**, including patient experience and quality of care
4. **Health care cost**, including total cost of care, utilization, and unit costs
5. **Status of health care reform efforts**, including state health care exchanges, Medicaid expansion, system initiatives to adopt value-based payment models and increase transparency, and adoption of health information technology (HIT)

Minnesota's health care system fares very well when compared with other states along these dimensions, and is ranked first in the nation overall.

The state's results are particularly impressive in coverage and access, health outcomes, and quality of care. It has among the lowest rate of uninsured in the country, and performs very well across most available quality and outcome measures. Minnesota has one of the country's healthiest populations, with fewer residents reporting "poor" or "fair" health than those of any other state. Minnesota also compares quite favorably in several aspects of system reform – most notably the adoption of health information technology (HIT), reporting, and transparency.

The state compares less well in health care cost, where it is ranked 22nd overall. This ranking reflects the average state rank across a number of measures of total cost of care, utilization, and unit cost. These measures are detailed in Chapter 2, and in the Performance Scorecard at the end of this report.

While total cost of care varies significantly by payer category, the available measures suggest that utilization levels are close to the national average and that unit costs are higher than average, even when controlling for case mix and wage index. These measures must be considered together with the state's high levels of coverage, access, and quality of care to create a comprehensive view of health care value. They must also be considered alongside growth in health care spending– which, though slightly lower than the national average in recent years, has outpaced growth in the state's GDP by two times over the past decade on a cumulative, per capita basis. While Minnesota has one of the best health care systems of any state along most dimensions of performance, it must contend with the same challenge of unsustainable spending growth facing the nation as a whole.

Overall, we identify four strengths and four areas of opportunity:

Areas of distinctiveness	Opportunities for improvement
• Nation-leading health care coverage and access to care	• Reduce growth in health care spending
• Advanced measurement and reporting infrastructure	• Address gaps in the treatment of populations with special needs
• High degree of care coordination and system integration	• Address gaps in the management of population health
• High quality of care and population health	• Mitigate disparities in health care access and outcomes

Recommendations

Based on this research, and in consideration of the systemwide changes currently underway, we propose six recommendations for actions that the business community should take in partnership with the state. These recommendations are intended to help realize the potential of health care reform in Minnesota, and to ensure that the changes underway address the state's most pressing needs by promoting greater efficiency, transparency, and consumer choice.

The six recommendations are:

1. Advocate to extend existing public–private partnerships for health care measurement to address gaps, better assess disparities, and promote greater accountability for providing affordable, high quality care
2. Bring leaders in the state's health care delivery and medical technology sectors together to partner on innovations designed to improve population health, patient experience, and affordability
3. Draw on best practices to inform consumers about their health and the health care system, and to promote greater consumer engagement
4. Promote best practices in employee and family wellness programs, including coordination across employers
5. Partner with state agencies to help them produce an implementation roadmap and performance accountability framework for reform initiatives and demonstrations
6. Share findings widely in the community to increase awareness of Minnesota's performance in health and health care, and of the efforts underway to further improve health in the state

1. INTRODUCTION

Challenges facing Minnesota's health care system

Minnesota is widely recognized as one of the country's healthiest states and as a national leader in health care. The state consistently ranks at the top of the list in UnitedHealth Foundation's America's Health Rankings, an annual report assessing determinants of health and health outcomes at the state level.[1] In 2013, Minnesota was ranked the third-healthiest state in America, overall, and the first in terms of health outcomes.These findings are consistent with those of other national studies of overall health system performance.[2]

The state's reputation for excellence in health care is due in part to its pioneering health plans, provider systems, and research organizations. Minnesota is home to a number of leading health plans with a long history of innovation in payment and care management. A few notable examples include HealthPartners, Medica, and BCBS Minnesota.

The state also claims several nationally and internationally recognized provider and research organizations, including the Mayo Clinic, Fairview Health Services, Essentia Health, Allina Health, and HealthPartners. As evidence of the excellent quality of care available in the state, the Mayo Clinic was recently recognized as the best hospital in the nation for 2014–15 by ***U.S. News & World Report.***[3]

Together, these organizations have made Minnesota a leading national laboratory for medical research and for innovation in health care payment and delivery models. The state has long been recognized as a leader in patient-centered, community-based care, and in integrated delivery models. It is home, for example, to three of the nation's 19 Pioneer Accountable Care Organizations, and some of the country's most widely respected health care home programs.[4]

While Minnesota has much to be proud of with respect to its health care system, it faces a number of challenges that have direct implications not just for the well-being of its population, but also for the state's economy. These challenges broadly mirror those straining the health care system nationwide. As is the case nationally, Minnesota is experiencing significant growth in the prevalence of costly chronic conditions and indicators of future health problems. The obesity rate, for example, has increased more than 10 percentage points over the past two decades, from 14.6% of the population in 1995 to more than 25% in 2010.[5] The percentage of adults in Minnesota diagnosed with diabetes has nearly doubled in this same time period.[6] Though still below the national average, these trends highlight a growing problem that will become increasingly difficult and costly to manage if not addressed.

Changing demographics pose another challenge. The aging of the population in Minnesota (and nationally) is increasing the disease burden and shifting costs to government-run health care programs. This shift will exacerbate regional disparities in health, as the proportion of the population over 65 is growing more quickly in the state's rural counties. Minnesota is also facing a distinct set of challenges associated with the changing composition of its population. The state's non-white population has grown from 6% in 1990 to more than 15% in 2010. This growth has been driven predominately by immigration, with the most rapid growth from Africa.[7] In future years, the state expects most population gains to be in communities of color. This growth in the immigrant population and the state's increasing ethnic and cultural diversity have many benefits, but also pose new challenges for local health care systems, which must address different underlying health needs and bridge increasingly varied cultural and linguistic barriers.

Finally, the state is grappling with the same unsustainable growth in health care spending that threatens the health care system nationwide. While the growth in total health care spending slowed considerably since 2008—due largely to the great recession—the long-term trend is not promising. Since 2005, health care spending has increased 35% while the state economy has grown by 22%.[8]

Health care reform

Policy makers and private sector leaders have undertaken an ambitious set of reforms in response to these challenges. Prior to national health care reform with the passage of the Affordable Care Act (ACA) in 2010, Minnesota passed its own, statewide Health Care Reform Act in 2008. This legislation built upon a broad set of public and private sector initiatives and experimental models already underway in the state to improve access to care and population health, increase transparency into provider cost and performance, accelerate payment reform, and promote greater consumer engagement. The key initiatives established by this law include:

- **Health care homes**. The 2008 Reform Act mandated the creation of a standardized, statewide medical home model to promote patient-centered primary care. This model included the establishment of a common set of standards for medical home certification, a certification process, and a payment methodology to compensate for care coordination.
- **Provider Peer Grouping (PPG).** As part of a broader effort to promote greater transparency into provider cost and quality, the reform law called for the creation of the Provider Peer Grouping (PPG) process. In order to do this, the Department of Health created the Minnesota Health Care Claims Reporting System (MHCCRS). This system collects and aggregates all payer encounter data. The All Payer Claims Database (APCD) was initially designed to support health care provider performance assessment as part of the Provider Peer Grouping initiative, but is under evaluation to support a broader set of applications.[9]
- **Statewide Health Improvement Program (SHIP).** TThe Reform Act established the SHIP to help local communities employ evidence-based population health strategies in schools, worksites, and health care settings to address lifestyle related health issues such as obesity and alcohol and tobacco consumption.
- **Statewide Quality Reporting and Measurement System (SQRMS).** The Reform Act mandated the establishment of a standardized set of quality measures to be used by providers statewide. SQRMS was designed to adopt measures created through Minnesota Community Measurement (MNCM) and to establish a framework for the ongoing development and reporting of measures through MNCM.

In addition to these new programs, the Health Care Reform Act also included a number of provisions designed to increase access to affordable health care coverage, promote the use of health information technology (HIT), and advance payment reform.

The 2008 Health Care Reform Act built upon more than 15 years of preceding legislation and innovations in health care reporting, payment, and delivery models driven collaboratively by the public and private sectors. This partnership between private and public sector leadership to advance statewide health care reform is one of the distinctive features of Minnesota's health care system. A timeline outlining the critical reforms of the past 20 years can be found in the Appendix, and a summary of some of the critical initiatives is provided in Exhibit 1.

Exhibit 1. Summary of key initiatives preceding the Reform Act of 2008

- **Coverage.** Minnesota has one of the lowest rates of uninsured in the country. This is the result of both higher than average private sector coverage and programs designed to ensure access for high-risk and low-income Minnesotans. The Minnesota Comprehensive Health Association (MCHA) was created in 1976 as the high-risk health insurance pool selling individual products to individuals who were denied coverage elsewhere because of pre-existing conditions. The MinnesotaCare program, a government-subsidized health plan, was created in 1992 to cover state residents with low to moderate incomes who are unable to afford insurance on their own but do not otherwise qualify for coverage under the state's traditional Medicaid program (Medical Assistance). MNCare effectively expanded Medicaid eligibility levels for low-income adults fifteen years before the national effort to expand coverage under the ACA.
- **Value-based payment.** Employers gave the state a head start in re-inventing health care purchasing and reimbursement. Business coalitions, such as Minnesota's Health Action Group (formerly the Minnesota's Buyer's Health Action Group) have been experimenting with programs that link provider reimbursement to outcomes well before the more recent national roll-out of Accountable Care Organizations (ACOs) and related models. Two notable innovations include Bridges to Excellence, a purchaser-led pay-for-performance program that rewards clinics based on performance on quality indicators, and eValue8, an online tool that provides member organizations with comparative cost and quality information on health plans. Other non-profit organizations, such as the Institute for Clinical Systems Improvement (ICSI), convene stakeholders to promote best practice care delivery and to accelerate system transformation. For example, in the spring of 2011, ICSI brought together the Minnesota Hospital Association, StratisHealth, hospitals, and community partners to implement its highly effective Reducing Avoidable Readmissions Effectively (RARE) Campaign, a statewide effort to reduce avoidable hospital admissions.
- **Measurement and transparency.** These innovations in payment structure were supported by activity in measurement and public reporting that allow for effective implementation of value-based payment arrangements. Minnesota Community Measurement, a commercial health plan-initiated group committed to public reporting of the healthcare sector's performance, produced a report on provider performance on select quality metrics for every clinic in the state, a feat that was the first of its kind in the nation in 2004. Patient Choice Healthcare Inc. was formed in 2000 as a program that sorted providers into tiers based on cost and quality on behalf of self-insured employers, one of many tools developed to make health plan and provider performance more transparent for purchasers and consumers.

In addition to these initiatives, Minnesota is also now engaged in a separate set of reforms that followed the passage of the Affordable Care Act. Despite the ongoing national political struggle over implementation of the ACA, Minnesota has largely embraced the law, including those elements left to the discretion of the states. It has opted to create its own state exchange and to further expand Medicaid coverage, and is actively participating in national pilots in care delivery and payment innovation. Minnesota was the first state to expand Medicaid in 2010 by extending coverage under its traditional Medical Assistance program to adults with incomes up to 75% of the Federal Poverty Level (FPL). [10] In March 2013, Governor Dayton signed MNsure, the state-based exchange, into law, making Minnesota one of 17 states to establish its own state-based marketplace.[11]

The state has also been an active participant in several programs run through the Centers for Medicare and Medicaid Innovation (CMMI) to design and test innovative payment and delivery models.[12]

Together, these varied public and private sector initiatives have created a period of dynamic change in Minnesota that will ultimately impact every component of the health care system, including regulators, payers, providers, and manufacturers, as well as consumers and employers.

The opportunity to build a healthier Minnesota

With so much at stake it is essential that the state's health care system stakeholders work together to make the most of the opportunity before us. The business community has a vital role to play in this effort. Minnesota's businesses benefit from the state's health care system and prosper with the good health of the population. They also have a responsibility to promote the good health of the communities in which their employees and customers live and work.

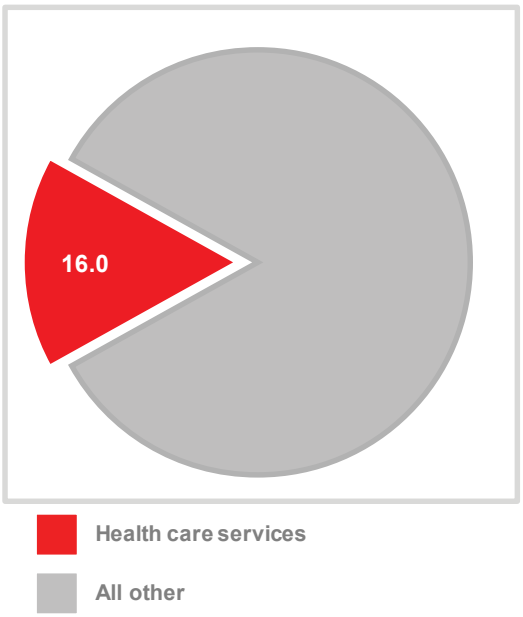
Through its active involvement and leadership on health care issues, the private sector has created a strong foundation for collaboration with the state and a unique platform from which to effect change. Twenty years of effective partnership have created networks and nonprofit organizations (such as the Institute for Clinical Systems Integration, Stratis Health, and Minnesota Community Measurement) which unite the state's employers, providers, and state agencies in the shared goal of improving health in the state.

The private sector's role in shaping the state's health care system is further strengthened by the remarkable concentration of world-class health care organizations based in Minnesota. In addition to the health plans and provider organizations previously noted, the state is also home to leading national payers, manufacturers, and medical technology companies. Two notable examples include UnitedHealthcare – the nation's largest private payer – and Medtronic, a world leader in medical device technology.

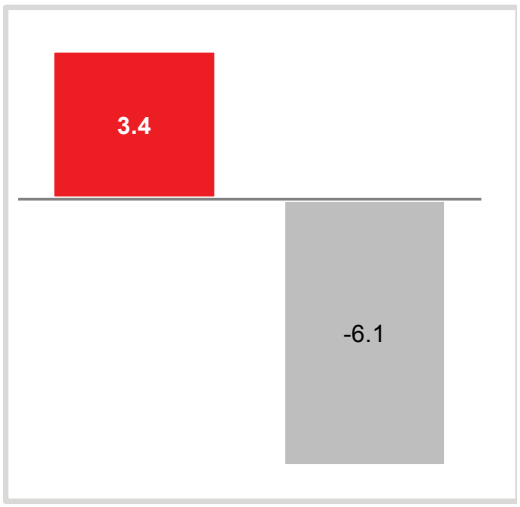
The health care sector, vital to the state's economy, accounts for a large and growing portion of the employment base; 16 of the state's top 50 employers are health care companies, which represent 32% of Minnesota's jobs.[13] These include health care providers, as well as health insurance companies, manufacturers, and medical technology companies. Health care providers alone employed more than 16% of the workforce in 2010 and are one of the economy's fastest-growing segments. Employment in the health care and social assistance sector grew 3.4% between 2008 and 2010, while all other industries experienced a 6.1% decline during the same period.[14]

Exhibit 2. Minnesota's health care sector employment statistics

Percentage of the workforce employed in health services, statewide (2010)



Growth in employment in health care vs. other industries (2008-2010)



Source: Minnesota Department of Employment and Economic Development analysis of Labor Market Information Office data, February 2011.

These organizations, critical to the health of the state's economy and to the social fabric of the cities and communities in which they operate, also offer a concentration of health care technical expertise and managerial experience that can be used to develop innovative, practical, and market-oriented health care initiatives.

The Minnesota Business Partnership is working to coordinate the leaders of these organizations and other large employers in the state. As a business coalition, MBP convenes the senior leaders of more than 100 of the state's largest employers and coordinates collective action to strengthen the state's economy and communities, and to promote health in the state. At this critical juncture in the evolution of the state's health care system, MBP and its membership are working to promote market-based reforms that achieve optimal health outcomes, reduce costs, and increase access to affordable care.

This report—and the Minnesota Health Care Performance Scorecard on which it is based—are intended to support this mission by providing a comprehensive, objective, and balanced assessment of the state's health care system. In the midst of rapid, disruptive change, it is essential that the decision makers and key stakeholders in the state have a clear and shared understanding of how the system is performing. We must know where the state is meeting its goals and where it isn't, and how access to care as well as the cost and quality of care are changing. The report compares the performance of the state's health care system with those of other states and the national average, so that we might better identify strengths to build on as well as gaps and opportunities for improvement. Drawing upon this research, the report makes a number of practical recommendations for how the state and the business community can work together to support and improve the health care system.

2. MINNESOTA'S HEALTH CARE SYSTEM IN NATIONAL PERSPECTIVE

Performance evaluation framework

The Minnesota Health Care Performance Scorecard is organized around five major dimensions of performance, as outlined in Exhibit 3. These dimensions are further broken down into 14 sub-categories, or domains. The five-part framework is grounded in the "Triple Aim," developed by the Institute for Healthcare Improvement (IHI). Widely used by health care organizations around the world, the Triple Aim assesses health care system performance as a function of three objectives: (i) to improve the patient experience (including quality and satisfaction of care); (ii) to improve the health of the population; and (iii) to reduce per capita cost of care.

We have built upon these three core dimensions (reflected in categories two through four on the scorecard) and expanded them to include two additional dimensions of health system performance: health care coverage and access, and the status of health care reform implementation.

Exhibit 3. Performance evaluation framework

Category		Domain		
1	Coverage and access	1.1	Health care coverage	
		1.2	System capacity and access	
2	Population health	2.1	Health care risk factors	Categories Adapted from the Triple Aim
		2.2	Prevalence and incidence	
		2.3	Health outcomes	
3	Health care delivery	3.1	Patient experience	
		3.2	Quality of care	
4	Health care cost	4.1	Total cost of care	
		4.2	Utilization	
		4.3	Unit cost	
5	Status of health care reform efforts	5.1	HIT adoption	
		5.2	System initiatives	
		5.3	Medicaid expansion	
		5.4	State health exchanges	

Source: McKinsey Health Care Value Analytics

The performance scorecard is organized around an aggregate view, summarizing the state's performance in all five categories, and more detailed, category-level views with supporting information. In total, the scorecard includes 154 performance metrics collected from more than 40 different sources. These metrics were drawn, wherever possible, from public sources so that the scorecard can be externally validated and replicated.

The scorecard includes both normative metrics, used to rank the state's performance, and descriptive measures, which are not used for ranking but convey important information.[15] The charts on the following pages report the state's performance on the normative metrics. The complete scorecard, including descriptive measures, is included in the appendix. The appendix also provides additional detail on the calculation of the state ranks and other aspects of the scorecard methodology.

The scorecard includes six years of data, covering 2009 to 2014. Data was not available for all of the metrics for all of the years in this time period. The scorecard always reports the most recent data, and the year of the most current data is reported for each metric in the detailed, category-specific views.

Scorecard results and highlights

Exhibit 4. Minnesota Health System Performance Scorecard summary

State rank (1-51)	Health system performance framework				Distribution of metrics by performance quintile (1-5)					Total metrics
	Category		Domain		1 (Top)	2	3	4	5 (Bottom)	
1	1	Coverage and access	1.1	Health care coverage	2					2
			1.2	System capacity and access	2		1			3
1	2	Population health	2.1	Health care risk factors	4	4	1	3		12
			2.2	Prevalence and incidence	4	2		1		7
			2.3	Health outcomes	9	2			1	12
4	3	Healthcare delivery	3.1	Patient experience		1				1
			3.2	Quality of care	4		1			5
22	4	Health care cost	4.1	Total cost of care	4	1	3	3	2	13
			4.2	Utilization	3	3	3	1	1	11
			4.3	Unit cost			1	3	2	6
5	5	Status of health care reform efforts	5.1	HIT adoption	2	1				3
			5.2	System initiatives	2			1		3
			5.3	Medicaid expansion		1				1
			5.4	State health care exchanges	1		1		1	3
1	State Total		Catetory weighted state average		48%	19%	17%	10%	6%	82

Legend

State Rank:

- State rank represents a forced ranking of 1-51 for each state and the District of Columbia
- Ranking is based on normative metrics, with a rank of 1 indicating best performance
- The ranks are color coded as follow:

State Ranking: 1-10 11-20 21-30 31-40 41-51

Distribution of metrics:

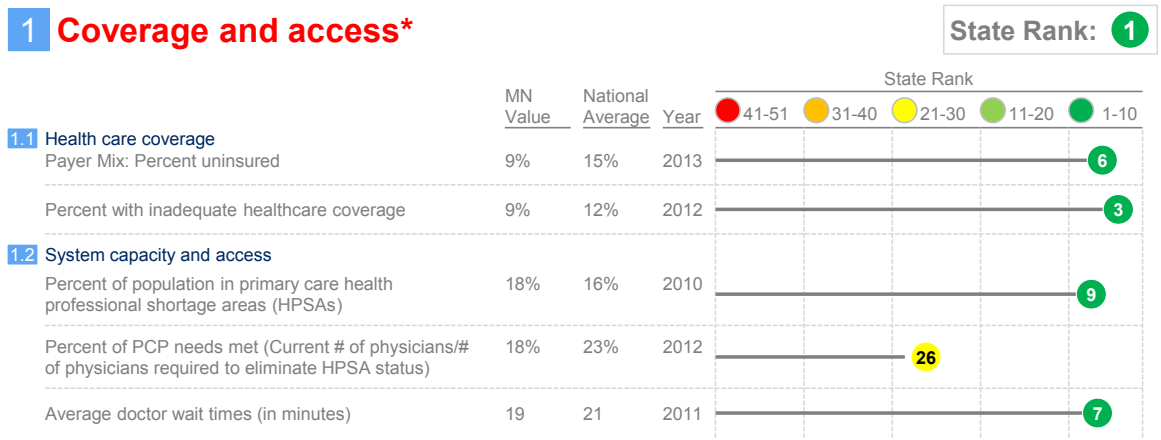
- The distribution of normative metrics are shown across performance quintiles
- Performance is scored so that it is preferable to be in the top quiintile (1) for any metric
- The concentration of performance metrics by quintile within a given domain is represented by the size of the circles, with larger circles indicating a greater concentration of metrics

76-100% of metrics 51-75% 26 -50% 1-25% 0% (#) Numbers in the circle represent individual performance metrics

Source: McKinsey Health Care Value Analytics and third party data sources

Overall, Minnesota's health care system fares very well in comparison with those of other states. It is ranked first in the nation, overall, across all five categories of performance, and fares particularly well in coverage and access, health outcomes, and quality of care. Nearly half of all of the normative metrics were in the top quintile in the most recent performance period, and nearly three-quarters were in the top two quintiles. This result is shown in the scorecard both in the aggregate statistics reported at the state level and in the distribution of metrics across quintiles at the domain level. The bubbles in the scorecard show the quintiles in which metrics are concentrated, with larger bubbles indicating a greater percentage of the metrics in a given domain. The numbers in the bubbles reflect the actual count of normative metrics in the specified domain and performance quintile.

Exhibit 5: Coverage and access



*See Appendix for complete scorecard including descriptive statistics
SOURCE: McKinsey Health Care Value Analytics and third party data sources

Minnesota ranked first in the country, overall, in coverage and access. In 2013, just 9% of the state's residents were uninsured, compared with 15% nationally.[16] This was the sixth-lowest rate in the country, and has since fallen even lower with the launch of state health insurance exchanges and the expansion of Medicaid. Minnesota ranks third-lowest in the country in the percentage of the population with inadequate coverage.[17]

Minnesota is also distinguished by the high proportion of the population covered by commercial insurance. In 2013, 62% of the state's population was privately insured, compared with 51% nationally. This high rate of commercial coverage reflects the state's low unemployment rate (4.5% compared with 6.2% nationally) as well a high rate of small businesses providing coverage to their employees.[18] The proportion of the population covered by Medicaid and Medicare is correspondingly lower than the national average, with 16% of the population covered by each program.[19]

While the percentage of the state's residents receiving care through safety net programs is lower than the national average, these programs are among the most generous in the country in terms of both eligibility and benefits. Thanks to the MinnesotaCare program created in 1992, Minnesota was one of the few states in the country that provided subsidized coverage to low-income adults not otherwise eligible for Medicaid before the ACA. The benefits the state Medicaid Program offers are also unusually generous, increasing beneficiaries' meaningful access to care.[20]

Measures of system capacity indicate that Minnesotans experience better-than-average access to acute care hospitals, specialist physicians, and trauma centers, as measured by the ratio of state population to providers. However, with 1,385 individuals per primary care physician (PCP) in the state—compared with a national average of 1,265 per PCP—residents in some parts of the state may have less access to primary care than those in other states.[21]

Insufficient access to primary care is more significant in some parts of Minnesota than others, but the disparity is less pronounced than in many other states. According to the U.S. Department of Health and Human Services, just 7% of the state's population lives in designated Primary Care Health Professional Shortage Areas (HPSAs), where there are more than 3,500 individuals per primary care physician. This rate is significantly below the national average of 20% but points to a potentially meaningful gap in access for segments of the state's population.[22]

Exhibit 6: Population health

2 Population health*

State Rank: 1

	MN Value	National Average	Year	State Rank
2.1 Health care risk factors				
Air Quality Index	0.81	0.68	2013	20
Injury deaths (per 100,000)	55	59	2010	11
Occupational fatalities (per 100,000 workers)	2.6	3.3	2012	14
Percent of adults reporting excessive drinking	18%	16%	2010	39
Percent of persons 12 and over with any illicit drug use in the past month	8%	9%	2011	24
Percent of adults reporting no exercise in the last 30 days	18%	23%	2012	6
Percent of adults reporting consumption of fewer than 5 servings of fruits / vegetables per day	78%	76%	2009	35
Percent of the adults who self-report cigarette smoking	19%	21%	2011	11
Percent of high school students reporting cigarette use in the last month	18%	18%	2011	29
Percent of adults designated as obese (BMI ≥ 30)	26%	28%	2012	14
Percent of children ages 10-17 that are designated as obese (BMI >95th percentile)	14%	16%	2011	19
Percent of adults with high blood pressure	22%	29%	2009	1
2.2 Prevalence and incidence				
Percent of Medicare beneficiaries with 2 or more chronic conditions	57%	69%	2012	7
Invasive cancer incidence rate (per 100,000)	476	459	2009	33
Percent of adults who have ever been told that they have diabetes	7%	9%	2010	4
Percent of adults who have ever been told that they have asthma	11%	14%	2010	4
Chlamydia case rate (per 100,000)	337.8	456.7	2012	8
Gonorrhea case rate (per 100,000)	57.7	107.5	2012	15
Percent of adults with mental illness	17.4%	17.8%	2011	14
2.3 Health outcomes				
Percent of adults that self-reported "poor" or "fair" health	12%	17%	2012	1
Gallup-Healthways Well-Being Index	69.7	66.2	2013	3
Stroke deaths (per 100,000)	36.1	39.1	2010	14
Alzheimer's disease deaths (per 100,000)	22.2	24.2	2010	18
Heart disease deaths (per 100,000)	122.1	182.8	2010	1
Influenza and pneumonia deaths (per 100,000)	10.3	16.5	2010	3
Homicide deaths (per 100,000)	1.8	5.5	2010	4
Suicide deaths (per 100,000)	10.8	11.8	2010	11
Infant mortality rate (per 1,000 live births)	4.5	6.1	2010	5
Percent of live births that are low birth weight	6.6%	8.1%	2011	5
Perinatal deaths (per 1,000 live births)	4.6	6.1	2010	6
Hospital rates of early scheduled delivery: Percent of mothers who indicated elective delivery as a percent of total mothers who delivered between 37-39 weeks of gestation	27%	17%	2010	19

State Rank: 41-51 | 31-40 | 21-30 | 11-20 | 1-10

*See Appendix for complete scorecard including descriptive statistics
SOURCE: McKinsey Health Care Value Analytics and third party data sources

Minnesota also performs well compared with other states in measures of population health. The state is ranked first in the country, overall, across measures of health care risk factors, prevalence and incidence, and health outcomes. This is consistent with the state's strong performance in America's Health Rankings, in which it ranked third, overall, in measures of predictors of health and health outcomes.

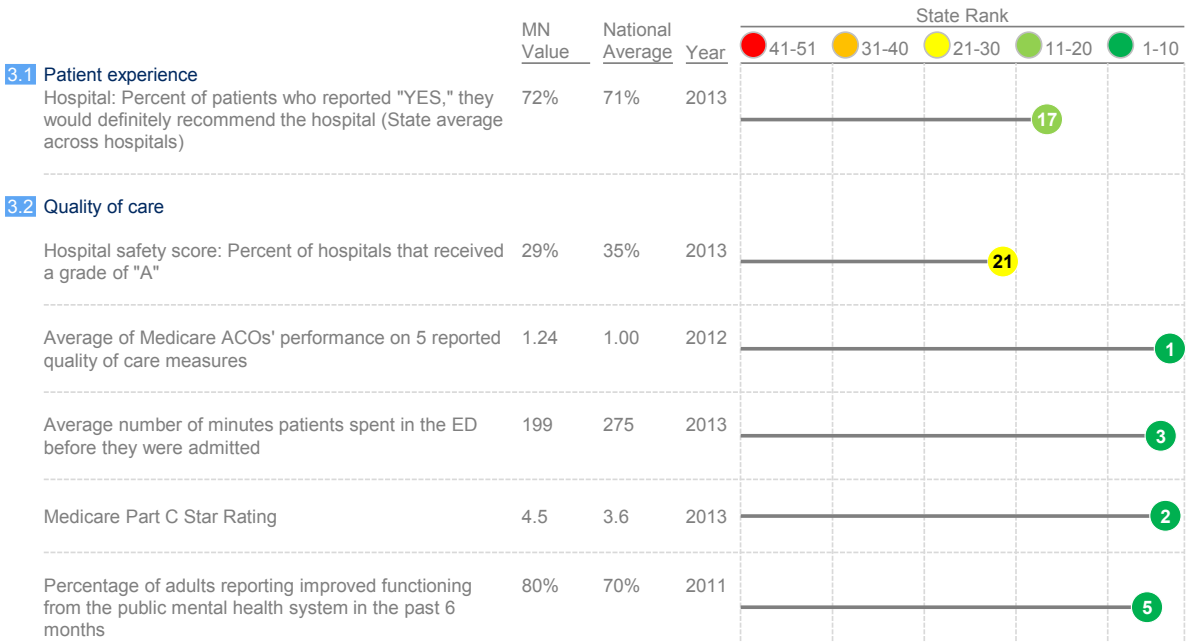
The state consistently scores well in key measures of health outcomes and disease prevalence. Minnesota had the lowest percent of its population, at 12%, reporting "poor" or "fair" health in 2012,[23] compared with the national average of 17%, and ranked third on the well-being index.[24] The state has the fourth-lowest percentage of adults who have been told they have diabetes or asthma.[25] The state mortality rate for heart disease is the lowest in the country, and measures of infant mortality and perinatal deaths are similarly low, ranking fifth and sixth out of all states respectively.[26]

Health care risk factors tell a slightly more varied story. Minnesotans have low rates of high blood pressure and lower rates of obesity than the national average. However, the state fares worse in measures of some unhealthy lifestyle behaviors, such as excessive drinking and poor diet, where it ranks 39th and 35th, respectively. It should be noted that while Minnesota appears worse than the national average on these measures, the gap is fairly modest. For example, Minnesota ranks 39th in the percent of adults who report excessive drinking, but the actual number (18%) is only 2% above the national average.[27]

Exhibit 7: Health care delivery

3 Health care delivery*

State Rank: 4



*See Appendix for complete scorecard including descriptive statistics
SOURCE: McKinsey Health Care Value Analytics and third party data sources

Measures of patient experience and quality of care are more difficult to assess as part of a national scorecard because levels and standards of reporting are highly inconsistent between states. State-level data are not available for many of the metrics included in this category, making it impossible to rank Minnesota for these. Inconsistency in reporting also complicates interpretation of the metrics for which national data are available. For example, Minnesota ranks very close to the national average in most measures of patient experience. However, it is difficult to know whether this is an accurate reflection of patient experience, as Minnesota's commitment to transparency delivers a much higher level of reporting.

Indicators of quality of care paint a mixed picture. There are several areas where Minnesota appears to fare very well. On average, the Minnesota-based ACOs participating in the Medicare Shared Savings and Pioneer ACO programs reported higher scores on select quality metrics than those of any other state.[28] The state ranked second in the country in its Medicare Part C Star rating, and fifth in the percent of adults reporting improved functioning following treatment in the public mental health system.[29]

Minnesota ranks near or below the national average in a few important measures, despite strong performance as a result of the measures being "topped out." This lower ranking occurs when all or most states perform very close to the best possible level, creating a cluster of results that renders ranks less meaningful. For example, 98% of patients undergoing surgery on an outpatient basis in Minnesota received antibiotics at the right time compared with 99% nationally, but this discrepancy caused the state to be ranked 34th in the country on this metric.[30] While the state rank is not incorrect, it is misleading for metrics like these for which the scores are so tightly distributed.

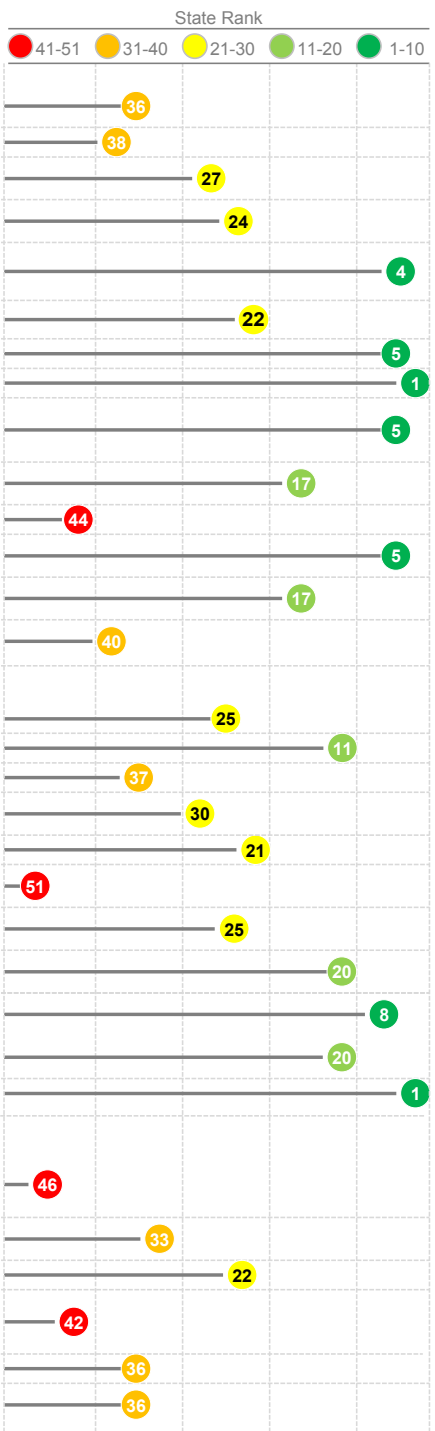
Two measures stand out, however, that point to potentially more meaningful gaps. In an aggregate measure of hospital safety, the Leapfrog Group, an independent national nonprofit patient safety organization, awarded only 29% of hospitals in Minnesota a hospital safety score of "A," compared with 35% of hospitals nationwide.[31] The percent of two-year olds who had received recommended immunizations also stands out. Minnesota ranked 39th in the country on this measure in 2012, with 66% of children meeting the standard, compared with 68.4%, nationally.[32]

Exhibit 8. Health care cost

4 Health care cost*

State Rank: 22

	MN Value	National Average	Year	State Rank
4.1 Total cost of care				
Per capita personal health care expenditures by state of residence	$7,409	$6,815	2009	36
Per capita hospital expense	$2,801	$2,411	2012	38
Total family premiums per enrolled employee at private-sector establishments (Average in dollars)	$15,408	$15,473	2012	27
Total premiums for private-sector employees enrolled in single coverage (Average in dollars)	$5,338	$5,384	2012	24
Total family premiums per enrolled employee at private-sector establishments (Average in dollars) as a percent of median household income	24.9%	30.3%	2012	4
Total medical costs per member per month for commercial health plans (State average in dollars)	$284	$291	2013	22
Total Medicare reimbursements per enrollee	$7,646	$9,584	2010	5
Part D spending per Medicare beneficiary	$1,927	$2,670	2010	1
CMS Medicare hospital spending per patient (Indexed to Medicare spending per patient on hospital care nationally)	0.90	0.98	2013	5
Medicare spending per decedent during the last two years of life	$58,963	$69,947	2010	17
Medicaid per enrollee payments: Total population	$6,230	$4,192	2011	44
Dual eligible enrollees: Duals' share of Medicaid spending	43%	36%	2010	5
Medicaid expenditure as a percent of total state expenditures	28%	24%	2012	17
Change in Medicaid expenditure as a percent of change in state GDP	-71%	233%	2013	40
4.2 Utilization				
Hospital admissions per 1,000 residents	108.4	109.7	2012	25
Hospital Emergency Room visits per 1,000 residents	352.9	424.4	2012	11
Average length of stay	6.0	5.4	2012	37
Commercial: Acute Hospital admissions per 1,000 members	57.9	56.2	2012	30
All-cause 30-day Medicare readmission rate	17.6%	19.1%	2011	21
Percent of outpatients with low back pain who had MRI without trying other treatments	50.9	36.5	2013	51
Percent of outpatients with brain CT scans who got a sinus CT scan at the same time	2.6	2.8	2013	25
Percent of outpatient CT scans of the chest that were combination•(double) scans	2.4	3.7	2013	20
Discharges for Ambulatory Care-Sensitive Conditions per 1,000 Medicare Enrollees	50.6	66.6	2010	8
Percent of Medicare decedents seeing 10 or more different physicians during the last six months of life	34	42	2010	20
Medicare Generic Dispensing Rate (GDR)	81	74	2010	1
4.3 Unit cost				
Commercial reimbursement per CPT: Index of payment for 100 most common physician office-based procedures	1.39	1.00	2012	46
Commercial reimbursement per DRG: Index of payment for 100 most common DRG discharges	1.05	1.00	2012	33
Cost per Acute Inpatient Admission	$14,611	$15,735	2012	22
Medicare Inpatient Prospective Payment System (IPPS) Geographic Adjustment Factor (GAF) (Average of Urban area-level weighted by Medicare discharges)	1.06	1.00	2012	42
Weighted average Medicare reimbursement per DRG	1.03	1.00	2012	36
Cost per inpatient discharge adjusted for wage index and case mix	$15,445	$13,731	2011	36



*See Appendix for complete scorecard including descriptive statistics
SOURCE: McKinsey Health Care Value Analytics and third party data sources

Minnesota performs least well on a comparative basis in measures of health care costs, ranking 22nd across the available measures. As previously noted, this ranking should not be taken at face value, as most of the cost measures are not adjusted for differences in case mix or wage index.

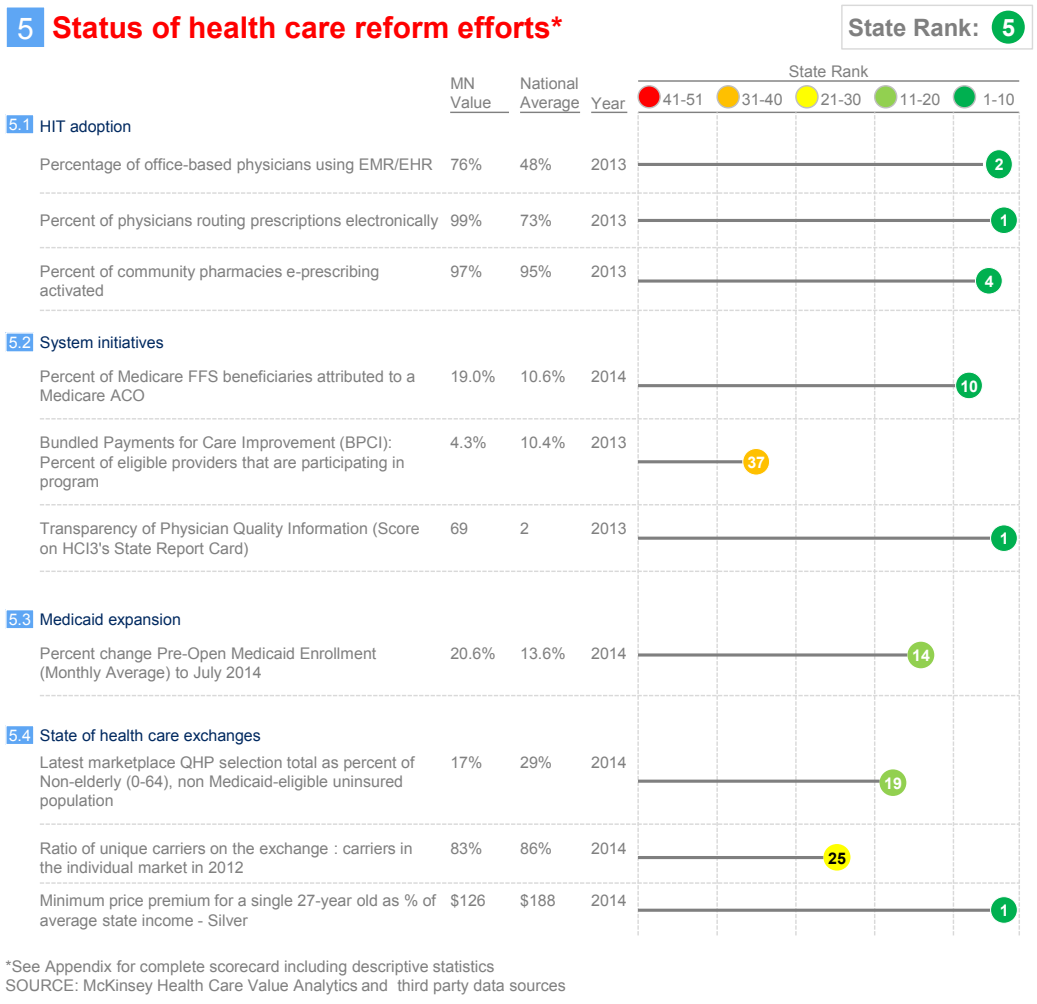
The measures of health care cost are divided into three domains: total cost of care, utilization, and unit costs.

With respect to total cost of care, the metrics tell a very different story across payment categories. Overall, Minnesota spends more per capita than the national average, ranking 36th in a 2009 study conducted by CMS. More recent research suggests that the total cost of care in Minnesota has grown more slowly in recent years than it has nationally (despite a marked reduction in the national trend). However, spending growth accelerated in 2012 after two years of very slow growth.[33] Relative levels of per capita spending look very different when broken down by segment. Medicare spending per beneficiary is among the lowest in the country (ranking 5th, overall), while Medicaid spending per enrollee is among the highest, ranking 43rd.[34] Per capita spending among the commercially insured is more difficult to measure but—judging by average premiums—appears closer to the national average.[35]

Measures of utilization tell a similarly mixed story. There are bright spots: the state has the country's highest generic dispensing rate (GDR) for Medicare beneficiaries, for example, and has a relatively low rate of emergency room visits.[36] Across such standard measures as hospital admissions per 1,000 residents, average length of stay, and hospital readmissions, the state performs close to the national average. There are also a few outliers in the other direction, for example, the state ranks 40th in the ratio of specialist visits to PCP visits.[37]

Importantly, Minnesota performs near or worse than the national average in most of the available measures of unit costs, even when controlling as much as possible for wage index and case mix. For example, the state ranked 36th in both the cost per inpatient discharge and for weighted average Medicare reimbursement per diagnosis related group, or DRG, a standardized classification of services provided in a hospital setting.[38] Perhaps most notably, the state ranked 46th in the average cost for the 100 most frequently performed procedures conducted in an outpatient setting and reimbursed through commercial insurance.[39] While this is not a perfect measure (it does not control for case mix or for variations in billing levels by procedure type), it suggests that physicians in Minnesota charge more on average per procedure than their counterparts in other states. The relatively higher commercial costs suggest that some cost shifting may be taking place, as providers charge more for patients covered by commercial plans to compensate for relatively low government rates.

Exhibit 9: State of health care reform efforts



Comparing states' performance in implementing health care reform initiatives is complicated by a number of factors. Not all states are doing the same things, and they are starting from very different points of development, working with different levels of resources, and facing different challenges. Further, imprecision in the available measures creates a tendency to measure activity rather than outcomes.

As previously noted, Minnesota passed and implemented its own reform law in 2008, and has since embraced the voluntary components of federal reform, opting to expand Medicaid and to develop a state-level health care exchange.

The comparative data reflect the impact of these many years of private and public sector innovation, particularly with respect to quality measurement and reporting, and adoption of HIT. Minnesota performs particularly well on indicators of transparency and public reporting.[40] The state has the highest rate of physicians routing prescriptions electronically of any state in the country, and the second-highest rate of physicians using electronic medical records (EMRs).[41]

Minnesota also shows a relatively high level of adoption of value-based payment models. It is tenth in the nation in the share of Medicare beneficiaries covered by Medicare ACOs,[42] and 43% of the state's primary care practices are certified as medical homes.[43] This compares with 10% of primary care practices certified as medical homes nationwide.[44] Uptake in programs based upon episode-based payment models has been low in the state compared with the national average.[45]

The measures pertaining to the state's performance with federal health care reform paint a mixed picture. The state exchange appears to be close to the national average in competitiveness, but is distinguished by a low proportion of plans on the exchange with narrow or very narrow networks.[46] Minnesota also has the lowest minimum premiums on the exchange of any state. (Premiums are expected to increase significantly in 2015.)[47, 48] Measures of market enrollment relative to the total potential market for exchange products ranks MNsure as having one of the lowest penetration rates in the nation, but this can be explained by the state's historically high rates of health insurance coverage.[49] Similarly, the change in monthly Medicaid enrollment relative to pre-open enrollment did not substantially exceed the national average, as Minnesota had in place very generous Medicaid eligibility levels, and acted on Medicaid expansion sooner than others.[50]

The scorecard does not reflect the difficulties that the state had in developing and implementing the state exchange, MNsure. As with several other states that opted to build their own state-based exchanges (as well as the federal government), Minnesota experienced a number of costly delays and technical difficulties in the initial rollout of the exchange. While many of these initial challenges are being addressed, operational issues and longer-term challenges persist.

3. STRENGTHS AND OPPORTUNITIES

The performance scorecard highlights many strengths of Minnesota's health care system. It also points to some gaps and areas where performance might be improved. The following section of the report describes the key themes that emerge from a systematic assessment of the scorecard data and third-party research on Minnesota's health care system. There are four areas of genuine distinctiveness in the health care system that we should seek to protect and build upon, and four areas where there are significant opportunities for improvement.

Areas of distinctiveness

The research highlights the system's four distinctive strengths, which warrant particular attention as the state proceeds with the implementation of health care reform. These four strengths are:

- Nation-leading health care coverage and access
- Advanced measurement and reporting infrastructure
- A high degree of care coordination and system integration
- Generally high quality of care and population health

Coverage and access

Minnesota is a national leader in health care coverage and access. It has consistently maintained one of the highest coverage rates of any state in the country, thanks to high rates of commercial coverage and very generous eligibility requirements for state-subsidized health insurance. Coverage rates and access have improved even further since the passage of the Affordable Care Act. Minnesota was 1 of 15 states (and the District of Columbia) to both implement a state-based health insurance exchange and expand Medicaid. The state's current eligibility levels for Medicaid (205% of FPL) are among the country's most generous, topped only by the District of Columbia.[51]

Between the launch of MNsure on October 1, 2013, and May 1, 2014, 180,000 uninsured Minnesotans gained health insurance coverage, representing a 40.6% reduction in the state's uninsured rate. The percent of state residents that are uninsured fell from 8.2% to 4.9%, the lowest rate in state records.

While coverage and access to care have improved, thanks to these actions, it will be important to monitor both as the market adjusts to new regulations and pricing structures. As elsewhere in the country, Minnesota might experience churn between coverage categories, and could yet see a shift away from employer-sponsored insurance into the individual market. Further, changes in plan design—including covered benefits and cost sharing—could have a harmful effect on access to care, even among the insured.

Measurement and reporting infrastructure

Minnesota is a pioneer in the measurement and reporting of health care data. The state's very high rates of health information technology (HIT) adoption tell only part of the story. Thanks to the remarkable partnership established between the public and private sectors in this area, Minnesota has been at the forefront of developing and reporting health care quality data.

Minnesota's modern health care measurement and reporting infrastructure had its origins in the health care reform efforts of the early 1990s, and the public–private partnership that was established at the time to improve the quality and cost-effectiveness of health care services. This partnership led to the creation of the Institute for Clinical Systems Improvement (ICSI), the Minnesota Health Data Institute (MDHI) and, in the early 2000s, Minnesota Community Measurement (MNCM). Initially sponsored by the health plans behind ICSI, MNCM published a statewide report—the first of its kind—assessing the performance of each individual medical group on a standard set of quality of care measures.

Minnesota's measurement and reporting movement was further advanced with the Health Care Reform Act of 2008, and the creation of the Statewide Quality Reporting and Measurement System (SQRMS). SQRMS requires physicians, clinics, and hospitals to submit the data needed to calculate performance on a specified set of quality indicators. The adoption of SQRMS as a statewide standard led to the adoption of the measurement platform that providers and plans had agreed to use in public reporting and led state programs to pay for quality programs. As a result, Minnesota is in the enviable position of having a "common scorecard" with which to compare performance.

Beyond the collection of quality and cost data, Minnesota is also a pioneer in developing quality and cost-of-care measures, several of which have been endorsed by the National Quality Forum (NQF) and adopted nationally.[52] These advances in measurement and reporting have laid a critical foundation for the shift to a more transparent, value-based health care delivery system. Continued partnership between the state's payers, providers, and policy makers will be required to ensure that these measures are used optimally in developing and implementing new accountable-care models, and to continue advancing the state's measurement system.

Care coordination and system integration

Minnesota's health care system is characterized by a high degree of integration. The health care landscape is dominated by large integrated delivery systems (IDSs) and health maintenance organizations (HMOs). There is also a high degree of physician consolidation, primarily through employment in large medical groups.[53]

The state's large IDSs and HMOs have historically driven much of the innovation in the health care sector, and have played a prominent role in advancing innovative payment and delivery models in the state. For example, Allina Health, Fairview Health Systems, and Park Nicollet Health Services (which recently merged with HealthPartners) make up 3 of the 19 Medicare Pioneer ACOs. Only Massachusetts and California have more ACOs in the Pioneer program.[54]

Minnesota has also been a leader in the development of health care homes. Commercial patient-centered medical homes (PCMHs), such as HealthPartners' BestCare program, were among the earliest in the nation. The state has one of the country's most comprehensive medical home certification and training programs, and nearly half of its primary care practices were certified by the end of 2013.

Programs to improve transitional care and coordination of services for special needs populations are additional examples of Minnesota's innovation in care coordination and integration. The state's dual-eligibles integration programs, for example, are among the country's most successful and longest running. In 1995, Minnesota became the first state to receive CMS approval for a payment demonstration that allowed fully integrated Medicare and Medicaid managed care contracts and financing to cover primary, acute, and long-term care services for seniors in the Minneapolis-St. Paul metro area. Since then, the state has developed a number of programs that experiment with different approaches to providing care for this population.[55]

High-quality care and health outcomes

Finally—and most importantly—Minnesota's health care system is distinguished by its performance delivering high quality care and health outcomes. It ranked first in the country in population health and in health outcomes, in the most recent America's Health Rankings.

Notable highlights include the lowest rates of infant mortality, years of potential life lost before age 75, and rate of mortality amenable to health care in the country.

These outcomes reflect the high quality of care provided by the health care system, the state's distinctive focus on quality measurement and reporting, and a collaborative approach to population health management.

It is difficult to benchmark Minnesota's providers accurately against other states on the basis of quality because there is so much variation in the volume, quality, and consistency of reporting. While the quality of care varies within the state, there is no question that Minnesota is home to a number of leading medical research and provider systems, and that the best care in Minnesota is among the best available.

Of course, the health of the population depends on more than just good health care. Recognizing this, public and private sector leaders, by promoting wellness and prevention programs, have shown a commitment to improving not only care delivery, but also health outcomes. Minnesota's hospitals and health plans are working collectively on community benefit and collaboration plans to streamline and leverage each other's efforts in population health improvement. Another significant effort is the Statewide Health Improvement Program (SHIP), created by the 2008 Reform Act, which is charged with improving overall population health through community-based programs.

Opportunities for improvement

While Minnesota's health care system has many strengths, it also has some notable gaps and opportunities for improvement. These include the opportunities to:

- Reduce growth in health care spending
- Address gaps in the treatment of populations with special needs
- Address gaps in the management of population health
- Mitigate disparities in health care access and outcomes

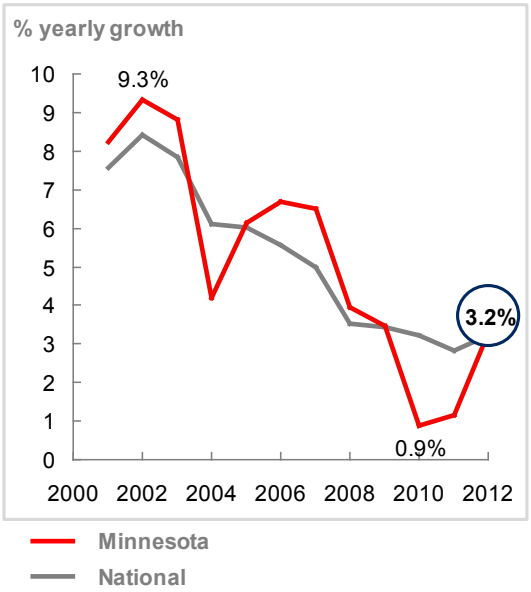
Health care spending

The most obvious opportunities for improvement emerging from the Performance Scorecard pertain to the cost of health care. Overall, Minnesota ranks 22nd among states across all measures of health care cost. This ranking should not be taken at face value as evidence of a problem. The publicly available measures on spending at the state level are imperfect, and it is not clear what the most desirable level of spending should be, as there is a relationship between spending and other aspects of system performance. Ultimately, it is the balance across the different categories that is most important.

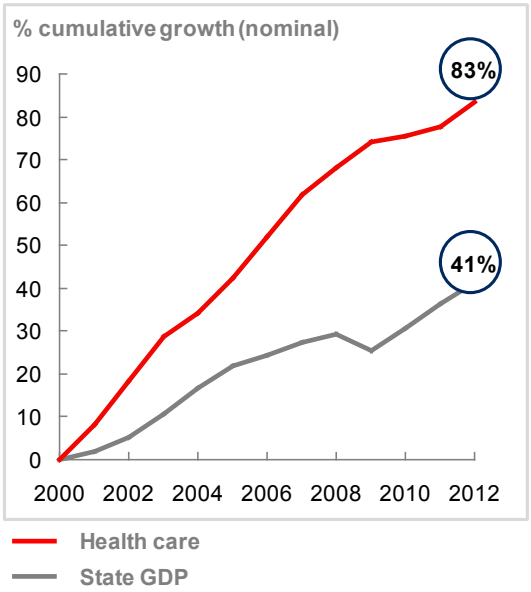
The data suggest, however, that there are opportunities to improve efficiency and better manage the cost of care, and that doing so will become increasingly important. The Performance Scorecard suggests that there may be opportunities to reduce spending growth by better addressing both utilization and unit costs (see Chapter 2). What the scorecard does not clearly show is why this is important. Addressing the spending trend remains a major priority as spending levels are growing at an unsustainable rate, putting pressure on employers and individuals to pay for care and straining the state budget. While spending growth on health care has slowed in Minnesota over the past few years—mirroring a national trend—the long-term trend is worrisome. Over the past decade, spending on health care has grown roughly twice as fast as state GDP. Between 2000 and 2012, per capita spending on health care grew 83% in Minnesota, while per capita GDP grew 41% (see Exhibit 10).

Exhibit 10. Growth in health care spending in Minnesota

Year on year growth in per-capita health care spending (2000-2012)



Cumulative, per-capita growth in health care spending vs. state GDP in Minnesota (2000-2012)



Source: McKinsey Health Care Value Analytics and third party data sources; U.S. Bureau of Economic Analysis; Minnesota Department of Health: Minnesota Health Care Spending and Projections, 2012

A number of private and public sector initiatives are currently being implemented to contain spending growth. In order to reduce costs in Medicaid, for example, the state instituted competitive bidding for health plans, added additional performance withholds and payment shifts for plans and providers, and began some demonstration programs to bring fee-for-service Medicaid into more accountable provider organizations.[56, 57]

Treatment of populations with special needs

Slowing the growth in the cost of care will require developing new solutions for the treatment of special needs populations. As elsewhere in the country, long-term care, and the treatment of patients with long-term disabilities and mental and behavioral health problems consume a disproportionate share of Minnesota's health care resources. For example, 43% of the Medicaid budget is dedicated to the treatment of dual eligibles, who represent only 15% of the enrollee population.

This problem is by no means unique to Minnesota. While the state spends more than others on some special needs populations (dual eligibles, for example), it does so largely as a consequence of its investment in innovative programs to improve coordination and delivery of care. Minnesota's programs for dual eligibles are considered to be among the country's best, and the state has taken action to address issues of mental illness.[58] Steps are also being taken to screen for and manage mental illness, especially among children.

While a number of innovative programs have been developed for the treatment of special needs populations in Minnesota (by both the state and private sector payers and providers), it is safe to say that they have not yet solved the problem of how to optimally manage care for these populations. Continued innovation with care delivery and management models, as well as new payment models, will be required and will need to be accompanied by systematic measurement and reporting to accurately ascertain how different programs are working.

Gaps in population health management

Minnesota has one of the healthiest populations of any state, and leads the nation in several outcome measures of health and wellness. However, there are gaps and meaningful opportunities for improvement. The Performance Scorecard highlights the opportunity to improve lifestyle behaviors that are detrimental to future health, for example, by reducing the frequency of binge drinking. The trend data also highlight causes for concern in the growth of the obesity rate and in the increased prevalence of diabetes. The obesity rate in Minnesota remains lower than the national average, but has increased more than 10% in the past two decades. The percent of adults in Minnesota diagnosed with diabetes has nearly doubled in this same time period, from 3.5% in 1994 to 6.5% in 2010.[59]

Additional opportunities can be found in the management of childhood health and broader social determinants of health. There appears to be an opportunity, for example, to improve education and awareness around best practices in maternal and prenatal care. In 2011, 14.4% of mothers reported smoking during pregnancy and 8% experienced maternal depression. Childhood immunization rates could also be improved.[60] These gaps are well recognized, and programs are in place to address them, but more remains to be done.[61]

Improving childhood health and the long-term health of the population will require addressing some of the social determinants of health. Childhood health is largely determined by social factors such as household income and parental education. The rate of child poverty in Minnesota remains lower, at 15%, than the national average, at 22%. However, the rate is as high as 49% in select racial groups.[62] More than one-third of children in the state are living below 200% of the federal poverty level. One-third of babies born in 2011 were delivered by unmarried mothers, and nearly one-quarter were born to mothers with a high school diploma or less.

Disparities in health care access and outcomes

The statistics on childhood poverty and other social determinants of health point to a broader opportunity to address a number of disparities in health care access and outcomes within the state. While Minnesota's health care system scores well on most dimensions of performance at the state level, statewide statistics mask some significant differences in health care and population health outcomes across geographies and between different sub-populations.

The Minnesota Department of Health (MDH) reports significant gaps both in social determinants of health and health outcomes between racial and ethnic groups. The child-poverty rate varies dramatically across racial groups, from 9% among white Minnesotans to 46% among African Americans and 49% among American Indians. The infant mortality rate among African Americans and American Indians is twice that for whites. The gap is particularly pronounced among American Indians, with mortality rates twice as high as those for whites between the ages of 1 and 14, and three times as great between the ages of 15 and 44.

We supplemented the publicly reported data released by MDH with a county-level analysis of select indicators from the Performance Scorecard to assess differences in health system performance across geographies. The results have been aggregated to eight regions.[63] As shown in Exhibit 11, there are significant differences between regions across each of the dimensions of performance.[64]

There is a marked difference between regions in terms of coverage and access to care. The Northwest has the lowest percentage of its population (49.5%) covered by commercial insurance, compared with the Metro region (63%), and the highest on Medicaid (22.7%), compared with that in the Southeast, which had the lowest (14.5%). The number of people per primary care physician also varies significantly, from a low of 842 in the Southeast to a high of 1,818 in the West Central Region.

Consistent patterns appear between regions in measures of population health and health care delivery, with the Metro and Southeast regions performing consistently better than other parts of the state. The adult obesity rate, for example, varies from a low of 24% in the Metro region to an average of 29% in more rural regions. In terms of patient experience and quality of care, the greatest gap is between the West Central Region—which comes in last for most measures of quality of care—and the Southeast. The difference is most pronounced in the measure of optimal care for children between the ages of 5 and 17: 54% of clinics in the Southeast met this standard, while just 11.3% of West Central clinics did.

It is important to note that the health of the population is due to much more than the performance of the health care system. While improving health care can of course improve population health outcomes and address some of the disparities outlined here, other social and environmental factors such as access to education and steady work, good nutrition, and reduction in crime play a major role in meeting these goals.

Exhibit 11. Health system performance: Regional disparities

	Date	Central	Metro	NE	NW	SC	SE	SW	WC	MN Avg
Population (Th)	2013	732	2,919	291	203	326	498	220	190	0 5,379
1 Coverage and Access										
1.1 Health care coverage										
% Uninsured	2013	9%	9%	9%	11%	9%	9%	10%	8%	9.1%
1.2 System capacity and access										
Population per primary care physician	2011	1,530	1,065	947	1,627	1,458	842	1,415	1,818	1,139
Population per dentist	2012	2,081	1,394	1,638	2,217	1,930	1,790	2,167	1,995	1,603
Population per mental health professional	2013	1,197	614	787	1,262	1,308	885	1,493	1,271	768
2 Population health										
2.1 Health care risk factors										
Diet: % of population who are low-income and do not live close to a grocery store	2012	5%	5%	9%	10%	7%	5%	11%	7%	6%
Food environment index: Index of factors that contribute to a healthy food environment	2011	8.7	8.6	8.0	8.0	8.5	8.9	8.2	8.6	8.5
Excessive drinking: % of adults reporting either binge drinking or heavy drinking	2012	21%	19%	18%	23%	21%	17%	18%	21%	19%
Adult obesity rate: % of adults that report a BMI >= 30	2010	28%	24%	28%	29%	29%	27%	29%	29%	26%
Adult smoking rate: % of adults that report smoking >= 100 cigarettes and currently smoking	2012	18%	15%	21%	22%	16%	14%	19%	18%	16%
Physical inactivity: % of adults aged 20 and over reporting no leisure-time physical activity	2010	21%	18%	20%	25%	23%	21%	24%	24%	20%
2.3 Health Outcomes										
Poor or fair health: % of adults reporting fair or poor health	2012	12%	10%	13%	11%	10%	9%	12%	12%	11%
Poor physical health days: Average number of physically unhealthy days reported in past 30 days (age-adjusted)	2012	3.1	2.8	3.1	2.7	2.5	2.5	2.7	3.0	2.8
Poor mental health days: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	2012	2.8	2.6	3.1	2.7	2.3	2.7	2.1	2.8	2.6
Low birthweight: % of live births with low birthweight (< 2500 grams)	2011	6%	7%	6%	6%	6%	6%	6%	6%	6%
3 Healthcare delivery										
3.1 Patient experience										
Physician Office: Getting care when needed: % of patients who gave the most positive rating possible	2013	60%	59%	61%	59%	59%	58%	60%	59%	59%
Physician Office: % of patients who gave the provider the most positive rating possible	2013	79%	79%	80%	77%	79%	80%	76%	78%	79%
3.2 Quality of care										
Optimal Care: Asthma - Children (5-17)	2013	48%	48%	43%	14%	32%	54%	25%	11%	44%
Optimal Care: Asthma - Adults (18-50)	2013	39%	42%	31%	12%	22%	39%	18%	10%	36%
Optimal Care: Diabetes - the D5	2013	34%	40%	30%	29%	36%	38%	33%	26%	36%
Optimal Care: Diabetes - Blood Pressure Control	2013	81%	85%	81%	80%	84%	82%	81%	76%	83%
Optimal Care: Vascular disease	2013	47%	53%	43%	44%	54%	53%	45%	40%	49%
Colorectal Cancer Screening	2013	65%	66%	63%	53%	62%	65%	58%	55%	63%
Depression: 6-month remission	2013	5%	7%	5%	2%	5%	8%	4%	2%	7%
Depression: 12-month remission	2013	5%	5%	6%	3%	4%	8%	3%	2%	5%
Depression: 6-month response	2013	9%	12%	10%	5%	8%	13%	6%	4%	11%
Depression: 12-month response	2013	8%	8%	10%	6%	7%	13%	5%	2%	8%
Depression: Use of PHQ-9	2013	67%	68%	60%	51%	69%	72%	59%	45%	64%
4 Healthcare cost										
4.2 Utilization										
Hospital admissions per 1,000 residents	2012	75	110	155	92	76	183	69	55	108
Medicare preventable hospital stays (Ambulatory Care Sensitive Conditions)	2011	57	45	49	57	54	50	54	47	49
4.3 Unit cost										
Cost per inpatient discharge adjusted for wage index and case mix ($Th)	2012	$ 19.0	$ 14.0	$ 29.2	$ 21.5	$ 30.4	$ 25.0	$ 26.6	$ 22.3	$ 15.4

Lowest Value Highest Value

4. THE PATH FORWARD

The strengths and opportunities highlighted by the Performance Scorecard point to several actions that should be taken to continue the improvement of the health care system. Much work is already underway. The following outlines some of those major initiatives as well as actions the business community can take in partnership with the state to navigate reform and optimize these efforts.

Next steps in health care system reform

Implementation of the 2008 Reform Act has been largely completed, though work remains with some key initiatives. The creation of a statewide Health Care Home (HCH) model, for example, has been generally successful, but penetration remains low in some regions, and the state is working with providers to address administrative concerns and continue to promote the program.[65] The Statewide Health Improvement Program (SHIP) has established a number of partnerships between state and local government agencies to promote community-based population health programs. Demonstrating the value of these programs has proven difficult, however, and SHIP is facing significant funding challenges that will need to be addressed.[66] Finally, the state's Provider Peer Grouping program was suspended in favor of other initiatives that measure cost and quality, and the state has commissioned a study to determine governance and alternative uses for the All Payer's Claims Database (APCD).

Implementation of federal health care reform also continues, and will represent a source of uncertainty in the market as the staged implementation of key programs proceeds and the repercussions of regulatory changes work their way through the system. The individual and small group markets will continue to undergo changes and Minnesota will need to ensure that its history of strong coverage and employer participation continues as the market adjusts to the new mandates, benefits, taxes and regulatory changes.

Finally, the health care system is evolving through extensive experimentation with new payment and care delivery models. This experimentation has been driven in part by the private sector and employers, as well as state and national programs. Building upon the foundation of their previous initiatives, many of the same organizations that helped drive health care system reform in Minnesota over the past two decades are currently working to promote greater adoption of accountable care models. They are also working to advance population health in the state through community health partnerships, innovative care models, and employer wellness programs.

Recommendations

The many reforms and initiatives underway in Minnesota have created a dynamic yet uncertain environment for employers and consumers. To help the business community and its public sector partners make the most of the promise of reform and navigate the challenges that it presents, we propose six broad recommendations. These recommendations are based on a few guiding principles

- They must address the gaps and opportunities outlined in Chapter 3 of this report: reduce growth in spending, address gaps in population health and the treatment of populations with special needs, and mitigate disparities in health care access and outcomes
- They should do so in ways that promote core principles of market efficiency, transparency, and consumer choice
- They should harness the unique capabilities of the private sector to contribute to improving the health care system and fostering healthier communities
- They should promote coordination in order to manage the complexity of the many reforms and overlapping initiatives planned and currently underway

These recommendations are not comprehensive. They are intended to provide employers with a set of discrete actions that they can take collectively to accelerate reform.

Recommendation 1: Advocate to extend existing public–private partnerships for health care measurement to address gaps, better assess disparities, and promote greater accountability for providing affordable, high-quality care.

Thanks to a unique history of collaboration between the public and private sectors—and driven by a sustained commitment to improving quality, choice, and market efficiency—Minnesota has one of the country's most robust quality measurement and reporting infrastructures. This asset enables continuous improvements in the quality of care, supports meaningful consumer choice, and lays the foundation for effective accountable care models, in which providers have direct responsibility for the cost as well as the quality of the care they deliver.

As impressive as the state's measurement and reporting systems are, there are three major ways in which they might be refined.

First, the quality measurement standards should be expanded to address recognized gaps and omissions. This expansion should start with the adoption of more system-level measures of children's health. There are currently very few systemwide measures with which to accurately assess children's health and the quality of health care services to children. Minnesota Community Measurement (MNCM) collects some good measures on prevention services, and the state has developed a patient-reported outcome measure for Asthma. Minnesota should build on this experience to develop measures for other important areas for children and their families, including patient experience, mental health, risky substance use, and injury prevention. Addressing this gap will help to establish an empirical foundation for the development of more effective children's health programs, and help target and reduce disparities in children's health outcomes.

Second, the state's excellent measurement and reporting system should be extended to include the performance of community-based population health programs. Effective population health programs will be an essential component of any plan to reduce the long-term cost trend and mitigate disparities in health outcomes. Unfortunately, these programs are notoriously difficult to evaluate, so determining which programs are working and which are less effective is often very difficult. Defining a common set of measurement standards and reporting conventions – including the assignment and recognition of accountability - will help standardize program evaluation and facilitate the identification and replication of the most effective models.

Finally, the standards should be expanded to include a common set of cost metrics—starting with a standard definition of the total cost of care—to supplement existing quality measures. This metric was approved as part of the 2008 Health Care Reform Act, but was not successfully implemented. Additional work has been done since then with providers across the state to adopt a standard measure of the total cost of care. Results of this work were released in late 2014. Minnesota should continue to lead in the testing and refinement of total cost of care measures applicable to primary, secondary and complex care. The addition of cost measures of this kind to the currently collected quality measures will be an essential step in promoting meaningful provider comparison and consumer choice, and – by extension – to improving quality of care and moderating cost growth.

Recommendation 2: Bring leaders in the state's health care delivery and medical technology sectors together to partner on innovations designed to improve population health, patient experience, and affordability.

Private sector health plans and providers in Minnesota have been a driving force in the continuous improvement and reform of the state's health care system. Since the early 1990s, several of the state's leading health care organizations have worked together and partnered with the state to drive improvements in measurement and reporting, innovation in care delivery and payment, system integration, and consumer engagement. This partnership remains at the heart of many of the state's most ambitious and promising reforms and pilot programs.

There is an opportunity to build upon this foundation and to further accelerate meaningful, market-based reform by expanding this partnership to better incorporate other leading health care companies based in the state – particularly those in the medical technology sector. Minnesota is home to a

number of leading health care organizations with a national or global presence. Companies like UnitedHealthcare and Medtronic, based in Minnesota, and other national organizations with a strong presence in Minnesota and expertise in health care, such as Boston Scientific and 3M, have a vested interest in improving the health care system and health in the state, and have a great deal to contribute thanks to their extensive experience in other markets, technical expertise, and resources. The plans and providers who have been leading reform in Minnesota should work to more actively engage these organizations, and leverage their unique capabilities to improve patient experience and population health while reducing per capita spending on health care (the Triple Aim). Since the health of the population is due to more than just health care, this partnership should extend to address other social and environmental determinants of health, such as access to education and steady employment.

Recommendation 3: Draw on best practices to inform consumers about their health and the health care system, and to promote greater consumer engagement.

The rapid changes taking place in the Minnesota health care system can be difficult for consumers to understand. This is particularly true for those seeking coverage in new ways. People who were previously uninsured or self-insured and are now purchasing plans through MNsure or as individual purchasers, for example, will likely experience a number of meaningful changes in the way they purchase coverage, the benefits provided by their new health plan, and potentially in the providers to whom they have access. Consumers need good information on plan coverage, out-of-pocket expenses, provider networks, and how to make the best choices for themselves and their families.

Employers and the larger business community have an important role to play in educating consumers about the changes in the system, the choices they must make, and the resources available to them. Employers should work together and with their local providers and health plan partners to share best practices in employee education and community-based consumer awareness programs. Coordination will help promote consistency in messaging and will allow employers to leverage a common set of resources.

Successfully implemented, these programs will help employees, their families, and local communities better navigate the system, make more informed choices, and live healthier lives. They will also help advance reforms based on transparency, accountability, and consumer choice, which depend upon informed consumers to advance quality and value.

Recommendation 4: Promote best practices in employee and family wellness programs, including coordination across employers.

Employers bear the brunt of rising premiums for employees and family members covered by employer-sponsored health plans, and are actively exploring opportunities to improve their health and wellbeing while reducing insurance and medical costs. Properly designed and implemented, wellness programs can improve employee happiness and productivity while reducing costs—the exact outcomes we aspire to achieve with the system statewide. Unfortunately, employers currently have limited exposure to case studies of successful programs and best practices outside of their own organizations.

We recommend that employers establish a collaborative learning forum to share best practices, and to disseminate evidence and supporting tools among themselves. This collaboration should include the adoption of common data collection and measurement standards in order to measure impact systematically and accurately. These efforts should extend to community-based programs with which these employers are connected in partnership with their health plans.

Recommendation 5: Partner with state agencies to produce an implementation roadmap and performance accountability framework for reform initiatives and demonstrations.

As a first step to plan for and navigate reform, the private sector should work with those state agencies tasked with implementing different reform efforts and demonstration projects and create a unified implementation roadmap and performance accountability framework. Minnesota's health care market is a crucible of experimentation, with multiple agencies and organizations simultaneously implementing overlapping programs. This overlap is particularly pronounced in the active experimentation with accountable care models. The plans, providers, and policy makers behind these programs are working to ensure coordination. For example, the Accountable Communities for Health being developed as part of the SIM testing grant builds on the existing Medicaid ACO demonstration. Performance metrics for these Accountable Health Communities will be important to measure success and to ensure sustainability. In addition, publicly reported metrics on enrollment and eligibility for state public programs and MNsure could help consumers understand the progress in modernizing the enrollment system and MNsure's performance.

Recommendation 6: Share findings widely in the community to increase awareness of Minnesota's performance in health and health care, and the efforts underway to further improve health in the state.

Finally, the private sector has an important role to play in helping promote understanding of the state's health care system and awareness of its performance among consumers across the state. Minnesotans are fortunate to live and work in a state that consistently ranks among the best in the country in terms of health outcomes and system performance. This is an accomplishment to be proud of, and a legacy to maintain. Coordination and engagement will be required at all levels if Minnesota is to stay at the forefront in population health, and to address the challenges and disparities outlined in this report. The private sector can help promote this engagement and further build upon its remarkable contributions in improving measurement, reporting, transparency, and consumer choice.

* * * * * * * * * * * * * * * *

These recommendations represent a set of practical actions that the business community can undertake in partnership with the state to capture the opportunity presented by the many reform initiatives underway in Minnesota. Together, they will help ensure that reforms address the most important opportunities for improvement, while promoting transparency, efficiency, and options for consumers. In the process, they will also help establish the foundation for the next horizon of reform, advancing accountable care, measurement, and effective community-based population health programs in order to improve outcomes, reduce disparities, and manage costs.

PERFORMANCE SCORECARD

Aggregate system scorecard

State rank (1-51)	Health system performance framework		Distribution of metrics by performance quintile (1-5)					Total metrics
	Category	Domain	1 (Top)	2	3	4	5 (Bottom)	
1	1 Coverage and access	1.1 Health care coverage	2					2
		1.2 System capacity and access	2		1			3
1	2 Population health	2.1 Health care risk factors	4	4	1	3		12
		2.2 Prevalence and incidence	4	2		1		7
		2.3 Health outcomes	9	2			1	12
4	3 Health care delivery	3.1 Patient experience		1				1
		3.2 Quality of care	4		1			5
22	4 Health care cost	4.1 Total cost of care	4	1	3	3	2	13
		4.2 Utilization	3	3	3	1	1	11
		4.3 Unit cost			1	3	2	6
5	5 Status of health care reform efforts	5.1 HIT adoption	2	1				3
		5.2 System initiatives	2			1		3
		5.3 Medicaid expansion		1				1
		5.4 State health care exchanges	1		1		1	3
1	State Total	Category-weighted state average	48%	19%	17%	10%	6%	82

Legend

State Rank:

- State rank represents a forced ranking of 1-51 for each state and the District of Columbia
- Ranking is based on normative metrics, with a rank of 1 indicating best performance
- The ranks are color coded as follow:

State Rank: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

Distribution of Metrics:

- The distribution of normative metrics are shown across performance quintiles
- Performance is scored so that it is preferable to be in the top quiintile (1) for any metric
- The concentration of metrics by quintile within a given domain is represented by the size of the circles, with larger circles indicating a greater concentration of metrics.

76-100% of metrics | 51-75% | 26 -50% | 1-25% | 0% | # Numbers in the circle represent individual performance metrics

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

1 Coverage and access

State Rank 1

✓ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

1.1 Health care coverage

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Percent of uninsured and underinsured								
✓ Payer mix: percent uninsured	2013	9%	15%	6	1	-1.5	↓ -0.2%	↓ -0.4%
✓ Percent with inadequate health coverage	2012	9%	12%	3	1	-1.5	N/A	N/A
Coverage by type								
Payer mix: percent commercial insured	2013	61%	51%	6	1	1.5	↓ -0.6%	↓ -0.2%
Payer mix: percent Medicaid beneficiaries	2013	16%	19%	33	4	-0.6	↑ 0.4%	↑ 1.2%
Payer mix: percent Medicare beneficiaries	2013	16%	16%	37	4	-0.1	↑ 0.4%	↑ 0.4%
High-deductible health plans: percentage of commercial enrollment covered by HSA/HDHP	2013	14%	7%	2	1	2.1	↓ -0.8%	↓ -0.8%
Percent of Medicaid eligible enrolled in managed Medicaid	2011	66%	74%	37	4	-0.4	↑ 2.1%	↑ 2.6%
Percent of Medicare eligible enrolled in managed Medicare (Medicare Advantage)	2013	50%	29%	1	1	1.9	↑ 2.8%	↑ 1.6%

1.2 System capacity and access

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Indicators of health system capacity								
Number of individuals per American College of Surgeons (ACS)-verified trauma center (in thousands)	2013	384	4,485	14	2	-1.9		
Number of individuals per primary care physician	2012	1,385	1,265	39	4	0.3		
✓ Percent of population in Primary Care Health Professional Shortage Areas (HPSAs): >3,500 individuals per PCP	2013	7%	20%	9	1	-1.0		
✓ Percent of PCP needs met (Current number of physicians/Number of physicians needed to eliminate the HPSA status)	2013	60%	60%	26	3	0.0		
Number of individuals per specialist	2012	675	717	13	2	-0.2		
Number of individuals per hospital (in thousands)	2012	40	63	16	2	-0.8		
Occupancy rates in community hospitals	2011	66%	64%	17	2	0.3		
Percent of hospitals with positive net income	2012	75%	69%	15	2	0.7		
✓ Average doctor office wait times (in minutes)	2013	16.7	20.3	7	1	-1.6		
Indicators of health system integration and consolidation								
System integration: percent of physicians employed by hospitals	2013	24%	25%	33	4	-0.1		
Percent of physicians belonging to a medical group	2013	58%	40%	2	1	2.0		
System integration: percent of hospitals in a system	2012	62%	62%	24	3	0.0		
System integration: percent of hospitals in a network	2012	23%	30%	37	4	-0.6		
Average number of physicians in a medical group	2013	39.8	19.4	6	1	0.8		
Indicators: Medicaid access								
Medicaid eligibility limits for parents of dependent children: percent of federal poverty level	2013	205%	N/A	50	5	N/A		
Medicaid eligibility limits for other non-disabled adults: percent of federal poverty level	2013	0%	N/A	1	1	N/A		
Medicaid eligibility limits for children (0-1): percent of federal poverty level	2013	288%	N/A	43	5	N/A		
Medicaid eligibility limits for children (1-5): percent of federal poverty level	2013	280%	N/A	45	5	N/A		
Medicaid eligibility limits for children (6-18): percent of federal poverty level	2013	280%	N/A	46	5	N/A		
Medicaid eligibility limits for pregnant women: percent of federal poverty level	2013	283%	N/A	48	5	N/A		
Dual eligible enrollees: duals as a percent of Medicaid enrollment	2010	15%	14%	23	3	0.3		
Distribution of Medicaid enrollees by enrollment group: percent of enrollees "Aged"	2010	10%	9%	13	3	0.4		

Continued >>

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

1 Coverage and access

State Rank 1

Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

1.2 System capacity and access

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Distribution of Medicaid enrollees by enrollment group: percent of enrollees "Disabled"	2010	14%	15%	29	4	-0.3		
Distribution of Medicaid enrollees by enrollment group: percent of enrollees "Adult"	2010	27%	27%	14	2	0.0		
Distribution of Medicaid enrollees by enrollment group: percent of enrollees "Children"	2010	48%	49%	36	4	-0.1		

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

2 Population health

State Rank 1

✓ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

2.1 Health care risk factors

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Environmental risk factors								
✓ Air Quality Index	2013	0.81	.68	20	2	1.1	↑ 0.00	↑ 0.04
✓ Injury deaths (per 100,000)	2010	55	59	11	1	-0.3	↑ 1.20	↑ 0.90
✓ Occupational fatalities (per 100,000)	2012	2.6	3.3	14	2	-0.3	↑ 0.36	↓ -0.05
Behavioral risk factors								
✓ Percent of adults reporting excessive drinking	2010	18%	16%	39	4	0.7	↓ -2.8%	↓ -0.4%
✓ Percent of persons 12 and over with any illicit drug use in the past month	2011	8%	9%	24	3	-0.3	↑ 1.2%	→ 0.0%
✓ Percent of adults reporting no exercise in the last 30 days	2012	18%	23%	6	1	-1.4	↓ -4.4%	↓ -3.1%
✓ Percent of adults reporting consumption of fewer than 5 servings of fruits/vegetables per day	2009	78%	76%	35	4	0.5	N/A	N/A
✓ Percent of adults who self-report as cigarette smoking	2011	19%	21%	11	1	-0.6	↓ -1.9%	↓ -0.6%
✓ Percent of high school students reporting cigarette use in the last month	2011	18%	18%	29	4	0.0	N/A	N/A
Other leading indicators of health risk								
✓ Percent of adults designated as obese (BMI ≥ 30)	2012	26%	28%	14	2	-0.6	→ 0.0%	↓ -0.2%
✓ Percent of children ages 10-17 designated as obese (BMI >95th percentile)	2011	14%	16%	19	2	-0.5	N/A	N/A
✓ Percent of adults with high blood pressure	2009	22%	29%	1	1	-2.1	N/A	N/A

2.2 Prevalence and incidence

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Chronic conditions, cancer, and common STDs								
✓ Percent of Medicare beneficiaries with 2 or more chronic conditions	2012	57%	69%	7	1	-1.8	N/A	N/A
✓ Invasive cancer incidence rate (per 100,000)	2009	476	459	33	4	0.6	N/A	N/A
✓ Percent of adults who have ever been told they have diabetes	2010	7%	9%	4	1	-1.2	↑ 0.3%	↑ 0.4%
✓ Percent of adults who have ever been told they have asthma	2010	11%	14%	4	1	-1.6	↑ 1.3%	↑ 0.3%
✓ Chlamydia case rate (per 100,000)	2012	337.8	456.7	8	1	-0.8	↑ 19.10	↓ -0.90
✓ Gonorrhea case rate (per 100,000)	2012	57.7	107.5	15	2	-0.8	↑ 14.60	↑ 3.30
Syphilis case rate (per 100,000)	2012	6.3	16.0	18	2	-0.7	↓ -0.60	↑ 1.20
✓ Percent of adults with mental illness	2011	17.4%	17.8%	14	2	-0.1	N/A	N/A

2.3 Health outcomes

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
General health outcomes								
✓ Percent of adults that self-reported "poor" or "fair" health	2012	12%	17%	1	1	-1.5	↓ -0.3%	→ 0.0%
✓ Gallup-Healthways Well-Being Index	2013	69.7	66.2	3	1	1.8	N/A	N/A
Mortality rates from common causes of death								
✓ Stroke deaths (per 100,000)	2010	36.1	39.1	14	2	-0.5	↑ 1.7	↓ -0.5
✓ Alzheimer's disease deaths (per 100,000)	2010	22.2	24.2	18	2	-0.3	↓ -1.2	↓ -0.9
✓ Heart disease deaths (per 100,000)	2010	122.1	182.8	1	1	-2.1	↑ 2.7	↑ 3.7
✓ Influenza and pneumonia deaths (per 100,000)	2010	10.3	16.5	3	1	-1.6	↑ 0.6	↑ 1.4
✓ Homicide deaths (per 100,000)	2010	1.8	5.5	4	1	-1.2	↓ 0.3	↑ -0.2
✓ Suicide deaths (per 100,000)	2010	10.8	11.8	11	1	-0.3	↓ -0.4	↓ 0.3

Continued >>

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

2 Population health

State Rank 1

Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

2.3 Health outcomes

Infant mortality rates and birth complications

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Infant mortality rate (per 1,000 live births)	2010	4.5	6.1	5	1	-1.3	↓ -0.1	↓ -0.3
Percent of live births with low birth weight	2011	6.6%	8.1%	9	1	-1.2	↑ 0.2%	→ 0.0%
Perinatal deaths (per 1,000 live births)	2010	4.6	6.1	6	1	-1.2	N/A	N/A
Hospital rates of early scheduled delivery: percent of mothers who indicated elective delivery as a percent of total mothers who delivered between 37-39 weeks of gestation	2010	27%	17%	19	5	1.7	N/A	N/A

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

3 Health care delivery

State Rank 4

✔ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

3.1 Patient experience

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
CAHPS measures of patient experience								
Physician Office, Access to Care: percent of patients who gave the physician the most positive rating possible (State average across clinics)	2012	60%	N/A	N/A	N/A	N/A		
Physician Office: percent of respondents that gave their provider a top rating of 9 or 10 on a 10-point scale (State average across clinics)	2012	78%	N/A	N/A	N/A	N/A		
Physician Office:, provider-patient communication: percent of patients who gave the most positive rating possible (State average across clinics)	2012	90%	N/A	N/A	N/A	N/A		
Physician office, courteous and helpful office staff: percent of patients who gave the most positive rating possible (State average across clinics)	2012	91%	N/A	N/A	N/A	N/A		
✔ Hospital: percent of patients who reported "YES," they would definitely recommend the hospital (State average across hospitals)	2013	72%	71%	17	2	0.3		

3.2 Quality of care

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Hospital and ACO performance ratings								
✔ Hospital safety score: percent of hospitals that received a grade of "A"	2013	29%	35%	21	3	-0.3		
✔ Average of Medicare ACOs' performance on 5 reported quality-of-care measures	2012	1.24	1.00	1	1	2.4		
Acute/Inpatient care								
✔ Average number of minutes patients spent in the ED before they were admitted	2013	199	275	3	1	-1.3		
Percent of outpatients having surgery who got an antibiotic at the right time (within 1 hour before surgery)	2013	98%	99%	34	5	N/A		
Percent of HF patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD)	2013	96%	97%	29	4	N/A		
Management of chronic conditions								
Percent of diabetes patients meeting target levels for modifiable risk factors (Hb1Ac, LDL, blood pressure, tobacco use)	2013	38%	N/A	N/A	N/A	N/A		
Percent of depression patients who have reached remission (PHQ-5 score < 5) within 6 months	2013	7%	N/A	N/A	N/A	N/A		
Controlling High Blood Pressure (BP): percent of patients 18-85 who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90)	2013	75%	N/A	N/A	N/A	N/A		
Screening and immunization								
Percent of women ages 24-64 who were screened for cervical cancer	2013	72%	N/A	N/A	N/A	N/A		
Percent of patients ages 51-75 who were up to date with appropriate colorectal cancer screening exams	2013	69%	N/A	N/A	N/A	N/A		
Percent of women 40-69 who had a mammogram to screen for breast cancer	2013	73%	N/A	N/A	N/A	N/A		
Childhood immunization status: percent of 2-year-old children who had CDC-recommended 4:3:1:3*3:1:4 series of immunizations	2012	66%	68%	39	N/A	-0.5		
Star Rating of Medicare Advantage plans								
✔ Medicare Part C Star Rating	2013	4.5	3.6	2	1	2.0		
Patient experience with public mental health system								
✔ Percent of adults reporting improved functioning from the public mental health system in the past 6 months	2011	80%	70%	5	1	1.3		

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

4 Health care cost

State Rank 22

Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

4.1 Total cost of care

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Per capita health care spending: all payer types								
Per capita personal health care expenditures by state of residence	2009	$7,409	$6,815	36	4	0.6	N/A	N/A
Per capita hospital expense	2012	$2,801	$2,411	38	4	0.5	↑ $93	↑ $158
Health care spending: Commercial								
Total family premiums per enrolled employee at private sector establishments (average in dollars)	2012	$15,408	$15,473	27	3	-0.1	↓ -$131	↑ $451
Total premiums for private sector employees enrolled in single coverage (average in dollars)	2012	$5,338	$5,384	24	3	-0.1	↓ -$88	↑ $162
Total family premiums per enrolled employee at private sector establishments (average in dollars) as a percent of median household income	2012	24.9%	30.3%	4	1	-1.3	↓ -1.9%	↑ 0.3%
Total medical costs per member per month for commercial health plans (state average in dollars)	2013	$284	$291	22	3	-0.1	↑ $20	↑ $8
Health care spending: Medicare								
Total Medicare reimbursements per enrollee	2010	$7,646	$9,584	5	1	-1.7	N/A	N/A
Part D spending per Medicare beneficiary	2010	$1,927	$2,670	1	1	-2.3	N/A	N/A
CMS Medicare hospital spending per patient (indexed to Medicare spending per patient on hospital care nationally)	2013	0.90	0.98	5	1	-1.6	N/A	N/A
Medicare spending per decedent during the last 2 years of life	2010	$58,963	$69,947	17	2	-1.2	N/A	N/A
Health care spending: Medicaid								
Medicaid per enrollee payments: Total population	2011	$6,230	$4.192	44	5	1.4	↓ -$2,025	↓ -$ 1,710
Medicaid per enrollee payments: Adults	2011	$3,845	$3,264	25	3	0.5	↑ $189	↑ $212
Medicaid per enrollee payments: Children	2011	$3,209	$2,090	43	5	1.7	↑ $266	↑ $91
Medicaid per enrollee payments: Aged	2011	$22,996	$11,500	40	5	2.0	↑ $1,429	N/A
Medicaid per enrollee payments: Blind/disabled	2011	$28,440	$17,591	43	5	2.0	↓ -$741	↑ $448
Dual eligible enrollees: Duals' share of Medicaid spending	2010	43%	36%	37	4	0.9	N/A	N/A
Medicaid expenditure as a percent of total state expenditures	2012	28%	24%	42	5	0.7	N/A	N/A
Change in Medicaid expenditure as a percent of change in state GDP	2011	3%	3%	35	4	0.6	↑ 0.1%	↓ -0.1%

4.2 Utilization

	Performance relative to national average					Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
General inpatient and emergency room care								
Hospital admissions per 1,000 residents	2012	108.4	109.7	25	3	0.0	↓ -3.1	↓ -2.1
Hospital emergency room (ER) visits per 1,000 residents	2012	352.9	424.4	11	1	-0.6	↓ -7.9	↑ 8.9
Average length of stay	2012	6.0	5.4	37	4	0.6	→ 0.0	→ 0.0
Commercial: Acute hospital admissions per 1,000 members	2012	57.9	56.2	30	3	0.3	↑ 0.64	↑ 0.04
Readmissions								
All-cause 30-day Medicare readmission rate	2011	17.6%	19.1%	21	2	-0.7	N/A	N/A
Rate of 30-day readmission for heart failure patients	2010	19.7%	21.1%	17	2	-0.9	N/A	N/A
Rate of 30-day readmission for pneumonia	2010	13.7%	15.3%	11	1	-1.1	N/A	N/A
Rate of 30-day readmission after all surgical stays	2010	10.7%	12.4%	14	2	-1.3	N/A	N/A
Scanning and diagnostics								
Percent of outpatients with low back pain who had MRI without trying other treatments	2013	50.9	36.5	51	5	3.7	N/A	N/A
Outpatients with brain CT scans who got a sinus CT scan at the same time	2013	2.6	2.8	25	3	-0.3	N/A	N/A
Outpatient CT scans of the chest that were combination (double) scans	2013	2.4	3.7	20	2	-0.6	N/A	N/A

Continued >>

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

4 Health care cost

State Rank 22

✓ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

4.2 Utilization

Other

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Ratio of specialist visits : PCP visits	2012	1.4	1.3	40	4	0.2	↑ 0.3	↑ 0.0
✓ Discharges for Ambulatory Care-Sensitive Conditions per 1,000 Medicare enrollees	2010	50.6	66.6	8	1	-1.1	N/A	N/A
✓ Percent of Medicare decedents seeing 10 or more different physicians during the last 6 months of life	2010	34	42	20	2	-0.8	N/A	N/A
✓ Medicare Generic Dispensing Rate (GDR)	2010	81	74	1	1	2.3	N/A	N/A

4.3 Unit cost

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Relative unit costs: Commercial								
✓ Commercial reimbursement per CPT: index of payment for 100 most-common physician office-based procedures	2012	1.39	1.00	46	5	1.4	↓ -0.05	→ 0.00
✓ Commercial reimbursement per diagnosis-related group (DRG): index of payment for 100 most-common DRG discharges	2012	1.05	1.00	33	4	0.3	↓ -0.02	→ 0.00
✓ Cost per acute inpatient admission	2012	$14,611	$15,735	22	3	-0.5	↓ -$509	↓ -0.3
Relative unit costs: Medicare								
✓ Medicare Inpatient Prospective Payment System (IPPS) Geographic Adjustment Factor (GAF) (average of urban area-level weighted by Medicare discharges)	2012	1.06	1.00	42	5	1.2	N/A	N/A
✓ Weighted average Medicare reimbursement per DRG	2012	1.03	1.00	36	4	0.2	↓ -1.0%	→ 0.0%
Hospital expenses per discharge: all payer types								
✓ Cost per inpatient discharge adjusted for wage index and case mix	2011	$15,445	$13,731	36	4	0.6	N/A	N/A

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

5 State of health care reform efforts

State Rank 5

✓ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

5.1 HIT adoption

	Performance relative to national average					Change from previous year	
HIT adoption	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
✓ Percent of office-based physicians using EMR/EHR	2013	76%	48%	2	1	2.3	⬆ 8.8%	⬆ 8.5%
✓ Percent of physicians routing prescriptions electronically	2013	99%	73%	1	1	2.2	⬆ 19.0%	⬆ 4.0%
✓ Percent of community pharmacies with e-prescribing activated	2013	97%	95%	4	2	1.1	⬆ 3.0%	⬆ 2.0%

5.2 System initiatives

	Performance relative to national average					Change from previous year	
Penetration of value-based care models	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
Percent of primary care practices that are Patient-Centered Medical Home (PCMH)-certified	2013	43.0%	10.0%	N/A	5	N/A		
✓ Percent of Medicare FFS beneficiaries attributed to a Medicare ACO	2013	19.0%	10.6%	10	1	0.7		
✓ Bundled Payments for Care Improvement (BPCI): percent of eligible providers participating in program	2013	4.3%	10.4%	37	4	-0.6		
Accountable care organizations (ACOs)								
Number of commercial and Medicare ACOs	2013	9	459	20	3	N/A		
Number of Medicare ACOs	2013	7	365	17	2	N/A		
Transparency and public reporting								
✓ Transparency of Physician Quality Information (score on HCI3's state report card)	2013	69	2	1	1	3.9		

5.3 Medicaid expansion

	Performance relative to national average					Change from previous year	
Medicaid expansion	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
✓ Percent change Pre-Open Medicaid Enrollment (monthly average) to July 2014	2014	20.6%	13.6%	14	3	0.4		
Percentage drop in uninsured (2010-2014)	2014	1%	3%	17	4	-0.6		

5.4 State of health care exchanges

	Performance relative to national average					Change from previous year	
Enrollment of eligible population	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
✓ Latest marketplace QHP selection total as percent of non-elderly (0-64), non-Medicaid-eligible uninsured population	2014	17%	29%	46	5	-0.7		
Health insurance marketplace enrollment as a share of potential marketplace population	2014	16%	28%	43	5	-1.0		
Exchange competitiveness								
Number of insurers in the individual health insurance marketplace	2014	5.00	4.00	19	3	0.3		
✓ Ratio of unique carriers on the exchange : carriers in the individual market in 2012	2014	83%	86%	25	3	-0.1		
Product and network design of plans on the exchange								
Product design: HMO and EPO products as % of all plans on the exchange	2014	22%	59%	34	4	-1.1		
Network design: products with narrow networks as % of all plans on the exchange	2014	17%	46%	42	5	-1.2		
Product pricing by metal tier								
Minimum price premium for a single 27-year old as % of average state income - Catastrophic	2014	$80	$126	2	1	-1.2		
Minimum price premium for a single 27-year old as % of average state income - Bronze	2014	$95	$149	1	1	-1.2		

Continued >>

Source: McKinsey Health Care Value Analytics and third-party data sources

Health system performance scorecard

5 Status of health care reform efforts

State Rank 5

✓ Metric included in aggregate scorecard | State Ranking: 1-10 | 11-20 | 21-30 | 31-40 | 41-51

5.4 State of health care exchanges

	Performance relative to national average						Change from previous year	
	Year	MN value	National Avg	State Rank	Quintile	SD from Nat Avg	MN	National Average
✓ Minimum price premium for a single 27-year old as % of average state income - Silver	2014	$126	$188	1	1	-1.3		
Minimum price premium for a single 27-year old as % of average state income - Gold	2014	$147	$214	1	1	-1.1		
Minimum price premium for a single 27-year old as % of average state income - Platinum	2014	$157	$254	1	1	-1.3		
2014 monthly premiums for a single 40-year old at 250% of FPL in a major city (benchmark plan)	2014	$154	$258	1	1	-1.8		
2014 monthly premiums for a single 40-year old at 250% of FPL in a major city (second-lowest cost Silver plan after subsidies)	2014	$154	$193	1	1	-4.4		
2014 Monthly premiums for a single 40-year old at 250% of FPL in a major city (Lowest-Cost Bronze Plan Before Subsidies)	2014	$115	$202	1	1	-1.7		
2014 Monthly premiums for a single 40-year old at 250% of FPL in a major city (Lowest-Cost Bronze Plan After Subsidies)	2014	$115	$130	10	1	-0.9		
Enrollment by metal tier								
Percent of marketplace enrollment under Bronze plan	2014	25%	20%	12	2	0.7		
Percent of marketplace enrollment under Silver plan	2014	34%	65%	49	5	-2.5		
Percent of marketplace enrollment under Gold plan	2014	12%	9%	20	3	0.6		
Percent of marketplace enrollment under Platinum plan	2014	27%	5%	1	1	3.3		
Percent of marketplace enrollment under Catastrophic plan	2014	1%	2%	24	5	-1.1		

Source: McKinsey Health Care Value Analytics and third-party data sources

TECHNICAL APPENDIX

1. Timeline of health care reform in Minnesota

1988	▪ **Buyers Health Care Action Group** (now called the Minnesota Health Action Group) created to represent interests of health care purchasers and promote improvement in the health care system
1992	▪ **MinnesotaCare** program established, expanding subsidized coverage for low-income adults ineligible for Medicaid
1993	▪ **Institute for Clinical System Improvement (ICSI)** established to promote development and use of evidence-based medicine ▪ **Minnesota Health Data Institute (MDHI)** created to improve HIT standards and infrastructure
2000	▪ **Patient Choice Healthcare Inc.** created to sort providers into tiers based on cost and quality **Minnesota Community Measurement (MNCM)** formed by health plans sponsoring ICSI to publish comparative data on patient care and outcomes statewide
2005	▪ Minnesota Buyer's Health Action Group establishes **Bridges to Excellence** to recognize and reward high-performing clinics
2006	▪ **Carol.com** founded as an early effort to create an online medical marketplace
2008	▪ **Transformation Task Force** publishes recommendations for health care reform ▪ **2008 Health Care Reform Act** passed ▪ **Statewide Health Improvement Project (SHIP)** created to support community-based population health programs ▪ Work begins to create **Statewide Quality Reporting and Measurement System (SQRMS)**
2009	▪ Work begins to create **All Payer Claims Database (APCD)**
2010	▪ **Northwest Metro Alliance** formed by HealthPartners and Alliance Health as a "learning lab" for ACOs ▪ **Medicaid expanded** under ACA ▪ Certification of **Health Care Homes (HCHs)** begins ▪ MN selected as 1 of 8 states to participate in the **CMS Multi-Payer Advanced Primary Care Practice** demonstration
2011	▪ **Community Transformation Grants (CTG)** program established with CDC funding to prevent chronic diseases ▪ **Reducing Avoidable Readmissions Effectively (RARE) program** established
2012	▪ National Quality Forum endorses MN's **Total Cost Index (TCI)**, the basis of efforts to determine Total Cost of Care ▪ **2012 Roadmap to a Healthier Minnesota** publishes recommendations to chart the next horizon of state-level system reform ▪ 32 **CMS Pioneer ACOs** are announced, including 3 in Minnesota
2013	▪ **SIM testing grant** awarded ▪ **MNsure launched**, allowing Minnesotans to purchase individual insurance on the exchange
2014	▪ **MNCM** launched and completed pilot program for **Total Cost Index (TCI)** with all major commercial health plans in the state and begins data collection to publicly report on the measure, possibly by the end of 2014

2. Acronyms

ACA	Accordable Care Act
ACO	Accountable Care Organization
ADHD	Attention Deficit Hyperactivity Disorder
AHA	American Hospital Association
APCD	All Payer Claims Database
BPCI	Bundled Payments for Care Improvement
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
DRG	Diagnosis Related Group
EMR	Electronic Medical Record
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level
GDP	Gross Domestic Product
GDR	Generic Dispensing Rate
HCH	Health Care Homes
HCI3	Heatlth Care Incentives Improvement Institute
HIT	Health Information Technology
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Areas
ICSI	Institute for Clinical Systems Improvement
IDS	Integrated Delivery System
MBP	Minnesota Business Partnership
MCHEC	Minnesota Center for Healthcare Electronic Commerce
MDH	Minnesota Department of Health
MDHI	Minnesota Health Data Institute
MHCCRS	Minnesota Health Care Claims Reporting System
MNCM	Minnesota Community Measurement
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PCMH	Patient-Centered Medical Home
PCP	Primary Care Physician
SCHSAC	State Community Health Services Advisory Committees
SHIP	State-wide Health Improvement Program
SIM	State Innovation Model
SQRMS	Statewide Quality Reporting Measurement System
TCOC	Total Cost of Care
TCRRV	Total Care Relative Resource Value
TPA	Third Party Administrator

3. Performance scorecard measure definitions

Measures are listed in order of appearance on the scorecard.

Category 1: Coverage and access

1.1 Health care coverage

Payer mix: percent uninsured: Percent of the population that does not have health insurance, based on HealthLeaders Interstudy's analysis of data from the U.S. Census Bureau "Small Area Health Insurance Estimate (SAHIE)" for uninsured figures for the population under 65 years of age. The estimate for persons 65 and over is a national estimate of 2%, based on current U.S. Census Bureau studies.

Percent with inadequate health coverage: Percent of the under-65 population that belongs to a household spending 10% or more of income on medical care (excluding premiums) or 5% or more if income is under 200% FPL, based on data from the Commonwealth Fund Health Insurance survey, a nationally representative telephone study of people age 10 and over in the continental U.S.

Payer mix: percent commercial insured: Percent of the population covered under commercial health insurance plans (individual, group, federal employee health benefit plan [FEHBP], consumer-driven health plan [CDHP], state/local employee plan, Blue Card HOME, student health and EPO) based on commercial medical enrollment from the HealthLeaders-Interstudy (HLI) National Medical and Pharmacy Census and population data from the U.S. Census Bureau and Census Bureau's Population Estimates Program.

Payer mix: percent Medicaid beneficiaries: Percent of total population receiving Medicaid benefits (including dual eligibles) based on data obtained by HLI directly from individual state insurance agencies and population data from the U.S. Census Bureau and Census Bureau's Population Estimates Program.

Payer mix: percent Medicare beneficiaries: Percent of total population receiving Medicare benefits based on data obtained by HLI from CMS and population data from the U.S. Census Bureau and Census Bureau's Population Estimates Program.

High-deductible health plans: percentage of commercial enrollment covered by HSA/HDHP: Percent of the commercially insured population enrolled in health savings accounts or high-deductible health plans.

Percent Medicaid eligible enrolled in Medicaid: Percent of Medicaid beneficiaries that are enrolled in MCO-managed Medicaid.

Percent Medicare eligible enrolled in managed Medicare (Medicare Advantage): Percent of Medicare beneficiaries enrolled in Medicare Advantage.

Category 1: Coverage and access

1.2 System capacity and access

Number of individuals per American College of Surgeons (ACS)-verified trauma center (in thousands): State population divided by the number of ACS-verified trauma centers, as reported by the ACS website.

Number of individuals per primary care physician: State population, as reported by the U.S. Census Bureau, divided by the number of primary care physicians (internal medicine, family medicine/general practice, obstetrics/gynecology, pediatrics), as reported by the Kaiser Family Foundation's analysis of State Licensing Information data.

Percent of population in Primary Care Health Professional Shortage Areas (HPSAs): >3,500 individuals per PCP: Percent of population residing in areas in which there are more than 3,500 individuals per primary care physician, as measured by the U.S. Department of Health and Human Services Health Resources and Services Administration.

Percent of PCP needs met (Current number of physicians/Number of physicians needed to eliminate the HPSA status): Current number of primary care physicians divided by the number of primary care physicians needed to eliminate the HPSA status that indicates there are more than 3,500 individuals per primary care physician, as measured by the U.S. Department of Health and Human Services Health Resources and Services Administration.

Number of individuals per specialist: State population divided by the number of specialist physicians, as reported by the Kaiser Family Foundation's analysis of State Licensing Information data.

Number of individuals per hospital (in thousands): State population divided by the number of hospitals, as reported by the American Hospital Association (AHA).

Occupancy rates in community hospitals: Average occupancy rate ((Inpatient days of care/Bed days available) x 100) for community hospitals, as reported by the AHA. Community hospitals are defined as all nonfederal, short-term general, and other special hospitals.

Percent of hospitals with positive net income: Percent of hospitals in the state that reported an excess of revenue over expenses in responding to the AHA's annual cost survey in 2012.

Average doctor office wait times (in minutes): Average time patients spent waiting in a doctor's office before being seen, as reported to Vitals, an independent surveyor of patient experience for over a million doctors, dentists, and medical facilities.

System integration: percent of physicians employed by hospitals: Number of physicians that responded "Yes" in a telephone survey on whether they were directly employed by a hospital or employed by a medical group that is owned by a hospital, as reported by SK&A Physician Directory in May 2013.

Percent of physicians belonging to a medical group: Number of physicians that responded "Yes" in a telephone survey on whether they belong to a medical group, as reported by SK&A Physician Directory in May 2013.

System integration: percent hospitals in a system: Percent of hospitals that reported being affiliated with a system to the AHA annual hospital survey in 2012. A system is defined by AHA as either a multi-hospital or a diversified single-hospital system. A multi-hospital system is two or more hospitals owned, leased, sponsored, or contract-managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25%, of their owned or leased nonhospital pre-acute or post-acute health care organizations. System affiliation does not preclude network participation**.**

System integration: percent of hospitals in a network: Percent of hospitals that reported belonging to a network to the AHA annual hospital survey in 2012. A network is defined by AHA as a group of hospitals, physicians, other providers, insurers, and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community. Network participation does not preclude system affiliation.

Average number of physicians in a medical group: Average number of physicians that reported "Yes" in a telephone survey on whether they belong to a medical group and reported belonging to the same medical group, as reported by SK&A Physician Directory in May 2013.

Medicaid eligibility limits: Eligibility levels are based on 2014 federal poverty levels and reflect modified adjusted gross income-converted income standards that include a five-percentage point of the federal poverty level disregard. Eligibility standards are based on a family of three for parents of

dependent children and on an individual basis for other adults. Figures are based on data from the CMS State Medicaid and CHIP Income Eligibility Standards effect April 1, 2014, accessed May 12, 2014.

Dual eligible enrollees: duals as a percent of Medicaid enrollment: Number of dual eligibles enrolled in the Medicaid program divided by the number of total Medicaid beneficiaries, based on estimates by the Kaiser Commission on Medicaid and the Uninsured and Urban Institute's analysis of 2010 data from the Medicaid Statistical Information Systems (MSIS).

Distribution of Medicaid enrollees by enrollment group: Enrollees by given enrollment group as a percent of total Medicaid beneficiaries. Enrollees: Individuals who are enrolled in Medicaid at any time during the federal fiscal year. **Aged:** Includes all people age 65 and older. **Disabled:** Includes people under age 65 who are reported as eligible due to a disability. **Adults:** Generally people age 19–64, including a small number of people who are eligible through the Breast and Cervical Cancer Prevention and Treatment Act of 2000. **Children:** Generally people age 18 and younger. However, some people age 19 and older may be classified as "children" depending on why they quality for the program and each state's practices.

Category 2: Population health

2.1 Health care risk factors

Air Quality Index: Air Quality Index is based on the EPA's AirData Air Quality Index Summary Report and represents a ratio of the state's annual days with Air Quality Index (AQI) less than 50 to national average annual days with AQI less than 50; value of greater than 1 represents a state with a greater number of "Good" days compared with the national average. AQI is an indicator of overall air quality, because it takes into account all of the criteria air pollutants measured within a geographic area.

Injury deaths (per 100,000): Total number of deaths for selected causes (*per the International Classification of Diseases, Tenth Revision*, 2nd Edition, 2004 codes *U01-*U03, V01-Y36, Y85-Y87, Y89) standardized to per 100,000 population, based on data from the CDC National Vital Statistics.

Occupational fatalities (per 100,000 workers): : Total number of fatalities from occupational injuries per 100,000 workers, as measured by the U.S. Bureau of Labor Statistics.

Percent of adults reporting excessive drinking: Percent of adults that reported either heavy drinking (15 or more drinks per week for men or 8 or more drinks per week for women) or binge drinking (drinking 5 or more drinks on occasion for men or 4 or more drinks on an occasion for women) on the CDC Behavioral Risk Factor Surveillance System (BRFSS) survey.

Percent of persons 12 and over with any illicit drug use in the past month: Based on responses to the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use & Health. Information on illicit drug use is collected for survey participants aged 12 and over. Information on any illicit drug includes any use of inhalants, as well as nonmedical use of prescription psychotherapeutic drugs. Current use (within the past month) is based on the question: "How long has it been since you last used (drug name)?"

Percent of adults reporting no exercise in the last 30 days: Percentage of adults who report, in their responses to the 2012 CDC Behavioral Risk Factor Surveillance Survey, doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their regular job in the last 30 days.

Percent of adults reporting consumption of fewer than 5 servings of fruits/vegetables per day: Based on responses to the CDC Behavioral Risk Factor Surveillance System (BRFSS): Six BRFSS questions assess fruit and vegetable intake and are the only diet intake questions on the core survey: "These next questions are about the foods you usually eat or drink. Please tell me how often you eat

or drink each one, for example, twice a week, three times a month, and so forth. How often do you..." 1) "...drink fruit juices such as orange, grapefruit, or tomato?" 2) "Not counting juice, how often do you eat fruit?" 3) "...eat green salad?" 4) "...eat potatoes, not including French fries, fried potatoes, or potato chips?" 5) "...eat carrots?" 6) "Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat?" Consumption was divided by 7 for weekly frequencies, 30 for monthly frequencies, and 365 for yearly frequencies to calculate daily consumption. Total daily consumption of fruit was the sum of responses to questions 1–2 and vegetables the sum of responses to questions 3–6. Participants were not given a definition of serving size.

Percent of adults who self-report cigarette smoking: Smoking prevalence is defined by the CDC BRFSS as the percentage of adults who self-report smoking at least 100 cigarettes in their lifetime and who are currently smoking.

Percent of high school students reporting cigarette use in the last month: Smoking prevalence is defined by the CDC BRFSS Youth Risk Behavior Survey as the percentage of adolescents in 9th–12th grades who report smoking on at least 1 day during the 30 days before the survey.

Percent of adults designated as obese: Percentage of adults who are obese, with a body mass index (BMI) of 30.0 or higher– based on responses to CDC BRFSS.

Percent of children ages 10-17 designated as obese (BMI > 95th percentile): Percent of children obese is defined as students who were ≥ 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts.

Percent of adults with high blood pressure: Percentage of adults who responded that they have been told by a health professional that they have high blood pressure in response to the CDC BRFSS.

Category 2: Population health

2.2 Prevalence and incidence

Percent of Medicare beneficiaries with 2 or more chronic conditions: Individuals that have been identified has having multiple (≥2) chronic conditions (from a set of 15 specified chronic conditions), based on CMS administration data.

Invasive cancer incidence rate (per 100,000): Figures are based on data collected from selected statewide and metropolitan area cancer registries that meet the data quality criteria for all invasive cancer sites combined, compiled by the CDC's U.S. Cancer Statistics Working Group. Figures have been age-adjusted to the 2000 U.S. standard population.

Percent of adults who have ever been told they have diabetes/asthma: Data based on the CDC's BRFSS, an ongoing, state-based, random-digit-dialed telephone survey of non-institutionalized civilian adults aged 18 years and older.

Chlamydia, Gonorrhea, and Syphilis case rates (per 100,000): Based on data from the CDC National Vital Statistics System and the MDH County tables.

Percent of adults with mental illness: Based on the Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Survey on Drug Use and Health's findings for "Any Mental Illness" (AMI) among adults aged 18 or older. AMI is defined as currently or at any time in the past 12 months having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association [APA], 1994).

Category 2: Population health

2.3 Health outcomes

Percent of population that self-reported "poor" or "fair" health: Based on sample respondents age 18 and older who self-reported fair or poor health status to the CDC BRFSS question: "Would you say that in general your health is – Excellent, Very good, Good, Fair, or Poor?" Figures were adjusted for age.

Gallup-Healthways Well-Being Index: The Gallup-Healthways Index is based on the survey responses of 500 Americans daily. The Index is calculated based on respondents' scoring on a 0–10 scale on question items across six domains: Life Evaluation, Emotional Health, Work Environment, Physical Health, Healthy Behavior, Basic Access.

Stroke/Alzheimer's disease/Heart disease/Influenza and pneumonia/Homicide/Suicide deaths (per 100,000): Based on data from the CDC National Vital Statistics System. Figures were adjusted for age.

Infant mortality rate (per 1,000 live births): Number of infant deaths per 1,000 live births based on linked birth and death records from the CDC National Vital Statistics System. Infants are defined as children under 1 year of age.

Percent of low-birth-weight live births: Number of babies born low birth weight, defined as less than 2,500 grams, as a percent of all live births, based on CDC National Vital Statistics System.

Perinatal deaths (per 1,000 live births): Number of fetal and infant deaths during the perinatal period (28 weeks of gestation to 7 days after birth) as a percent of the number of live births plus fetal deaths of at least 28 weeks gestation, based on the Link Birth/Infant Death Data Set by the CDC's National Vital Statistics System.

Hospital rates of early scheduled delivery: percent of mothers who indicated elective delivery as a percent of total mothers who delivered between 37–39 weeks of gestation: Based on hospital responses to the Leapfrog Hospital Survey.

Category 3: Health care delivery

3.1 Patient experience

CAHPS measures of patient experience: Based on Minnesota-specific data collected by Minnesota Community Measurement and national data published by the NCQA. Hospital-specific measure of "Percent of patients who reported, 'Yes,' they would definitely recommend the hospital" is based on Hospital CAHPS Patient Survey Results released by CMS Hospital Compare.

Hospital safety score: percent of hospitals that received a grade of "A": The Hospital Safety Score uses 28 national performance measures from the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services to produce a single score representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. Source: Hospital Safety Score (http://www.hospitalsafetyscore.org/).

Category 3: Health care delivery

3.2 Quality of care

Average of Medicare ACOs' performance on 5 reported quality-of-care measures: Figures represent state-level raw averages across all Medicare ACOs in the state using quality indicators reported by Medicare.gov: Accountable Care Organization (ACO) Quality Reporting (http://www.medicare.gov/physiciancompare/aco/search.html).

Acute/inpatient care quality of care indicators (Average number of minutes patients spend in the ED before they were admitted, Percent outpatients having surgery who got an antibiotic at the right time, Percent of HF patients given ACE inhibitor or ARB for left ventricular systolic dysfunction): Based on hospital quality information released by CMS Hospital Compare (http://www.medicare.gov/hospitalcompare/search.html).

Management of chronic conditions (Percent of diabetes patients meeting target levels for modifiable risk factors, Percent of depression patients who have reached remission, Percent of patients 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled): Based on Minnesota-specific data published by MNCM in their annual Health Care Quality Report (http://mncm.org/reports-and-websites/reports-and-data/).

Screening and immunization (Percent of women ages 24–64 who were screened for cervical cancer, Percent of patients ages 51–75 who were up to date with appropriate colorectal cancer screening exams, Percent of women 40–69 who had a mammogram to screen for breast cancer): Based on Minnesota-specific data published by MNCM in their annual Health Care Quality Report (http://mncm.org/reports-and-websites/reports-and-data/).

Childhood immunization status: percent of 2-year-old children who had CDC-recommended 4:3:1:3*3:1:4 series of immunizations: Based on data from National Immunization Survey (NIS). Estimated vaccination coverage among children 19–35 months for combined vaccination series known as 4:3:1:3*3:1:4 series, referred to as routine, that includes ≥4 doses of DTaP, ≥3 doses of poliovirus vaccine, ≥1 doses of measles vaccine, full series of Hib (3 or 4 doses, depending on product), ≥3 doses of HepB, ≥1 doses of varicella vaccine, and ≥4 doses of PCV.

Medicare Part C Star Rating: State averages represent the average of health insurance product Part C Star Ratings within the state weighted by enrollment by product. Based on data from CMS.gov: Part C and D Performance Data.

Percentage of adults reporting improved functioning from the public mental health system in the past 6 months: Based on the Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Survey on Drug Use and Health.

Category 4: Health care cost

4.1 Total cost of care

Per capita personal health care expenditures by state of residence: Based on CMS National Health Expenditures Health Accounts by state of residence. NHE presents aggregate and per capita estimates of personal health care spending by type of establishment delivering care (hospitals, physicians and clinics, nursing homes, etc.) and for medical products (prescription drugs, over-the-counter medicines, and sundries and durable medical products such as eyeglasses and hearing aids), purchased in retail outlets.

Per capita hospital expense: Includes all operating and non-operating expenses for registered US community hospitals, defined as non-federal, short-term, general, and other special hospitals whose facilities and services are available to the public, adjusted for state population, as reported to the American Hospital Association's Annual Survey. It is important to note that these figures are only an estimate of expenses incurred by the hospital to provide a day of inpatient care and are not a substitute for either actual charges or reimbursement for care provided.

Total family premiums per enrolled employee at private sector establishments (average in dollars), Total premiums for private sector employees enrolled in single coverage (average in dollars): Based on the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey's Insurance Component (http://meps.ahrq.gov/survey_comp/ic_technical_notes.shtml).

Total family premiums per enrolled employee at private sector establishments (average in dollars) as a percent of median household income: MEPS survey responses for "Total Family Premium per Enrolled Employees" divided by state median household income (as reported by American Community Survey).

Total medical costs per member per month for commercial health plans (state average in dollars): Based on NAIC filings aggregated by SNL Financials. Figures reported "Health Provisions Paid" by "Member months" as reported by commercial health insurance companies.

Total Medicare reimbursements per enrollee: Medicare reimbursements per enrollee (Parts A and B), adjusted for price, age, sex, and race.

Part D spending per Medicare beneficiary: Numerator: Part D event records were used to calculate individual-level total Part D prescription spending. Denominator: Prescription drug utilization and spending rates used a 40% Medicare random-sample denominator file for each year from 2006–2010. For the 2010 Part D enrollment cohort, patients were included if they were (1) age 65 or older as of 1/1/2010, (2) alive and continuously enrolled in a stand-alone Medicare Part D plan for all 12 months of 2010, and (3) not enrolled in hospice or a managed Medicare plan (Medicare Advantage) at any time during 2010.

CMS Medicare hospital spending per patient (indexed to Medicare spending per patient on hospital care nationally): The "Medicare hospital spending per patient (Medicare Spending per Beneficiary)" measure shows whether Medicare spends more, less, or about the same per Medicare patient treated in a specific hospital, compared with how much Medicare spends per patient nationally. This measure includes any Medicare Part A and Part B payments made for services provided to a patient during the 3 days prior to the hospital stay, during the stay, and during the 30 days after discharge from the hospital. The data displayed here are the average measures for each state.

Medicare spending per decedent during the last 2 years of life: Includes spending from MedPAR, Home Health Agency, Hospice and DME, the Part B file, and the Outpatient file; rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least-squares regression.

Medicaid per enrollee payments: Divided total payment by Basis of Eligibility (BOE) by total enrollment for BOE category data from the Medicaid Statistical Information Systems. Adjusted total population per enrollee spend figure to reflect the weighted average spend by eligibility category, calculated as average expenditure per beneficiary for each BOE category.

Dual eligible enrollees: Duals' share of Medicaid spending: May 2010 MA State/County Penetration File and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS. MSIS data from 2009 were used for Colorado, Idaho, Missouri, North Carolina, and West Virginia, because 2010 data were unavailable.

Medicaid expenditure as a percent of total state expenditures, Change in Medicaid expenditure as a percent of change in state GDP: The National Association of State Budget Office's estimates.

Category 4: Health care cost

4.2 Utilization

Hospital admissions per 1,000 residents, Hospital emergency room visits per 1,000 residents: Figures based on community hospital responses to the AHA Annual Survey. Community hospitals are

all non-federal, short-term general, and specialty hospitals whose facilities and services are available to the public and represent 85% of all hospitals.

Average length of stay: Average length of time between a patient's admission date and date of discharge, based on Avalere Health analysis of American Hospital Association Annual Survey data for community hospitals.

Commercial: Acute hospital admissions per 1,000 members: Number of hospitals admissions per 1,000 health plan enrollments, based on commercial claims data made available by Truven Health Analytics.

All-cause 30-day Medicare readmission rate: The 30-day death (mortality) measures are estimates of deaths from any cause within 30 days of a hospital admission, for patients hospitalized with one of several primary diagnoses. Deaths can be counted in the measures regardless of whether the patient dies while still in the hospital or after discharge. CMS chose to measure death within 30 days instead of inpatient deaths to use a more consistent measurement time window because length of hospital stay varies across patients and hospitals. Also, mortality over longer time periods (such as 90 days) may have less to do with the care received in the hospital and more to do with other complicating illnesses, patients' own behavior, or care provided to patients after hospital discharge.

Percent outpatients with low back pain who had MRI without trying other treatments, Percent outpatients with low brain CT scans who got a sinus CT scan at the same time, Percent outpatient CT scans of the chest that were combination (double) scans: Outpatient imaging efficiency measures apply only to Medicare beneficiaries enrolled in fee-for-service Medicare who were treated as outpatients in hospital facilities reimbursed through the Outpatient Prospective Payment System (OPPS). They do not include Medicare managed care patients, non-Medicare patients, or patients who were admitted to the hospital as inpatients. CMS calculates imaging efficiency measures using data from claims that hospitals and physicians submit for Medicare beneficiaries enrolled in Original Medicare. The data are calculated only for hospitals paid through the Outpatient Prospective Payment System (OPPS). Outpatient imaging efficiency measures are not risk adjusted. However, these measures do not include cases where there are clear medical reasons for performing the tests.

Ratio of specialist visits: PCP visits: Ratio of office-based visits to medical specialists and primary care physicians; analysis is based on 2010–2012 Truven Commercial Dataset.

Discharges for Ambulatory Care-Sensitive Conditions per 1,000 Medicare enrollees: 100% of Medicare enrollees age 65–99 with full Part A entitlement and no HMO enrollment during the measurement period; rates are adjusted for age, sex, and race using the indirect method, with the U.S. Medicare population as the standard.

Percent of Medicare decedents seeing 10 or more different physicians during the last 6 months of life: The number of physicians seen in the last 6 months of life is computed based on the Unique Provider Identification Number (UPIN) on the Part B claim; rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least-squares regression.

Medicare Generic Dispensing Rate (GDR): Prescriptions Filled with Generic Products was calculated as the difference between total 30-Day Prescriptions Filled and 30-Day Prescriptions Filled with Brand-Name Products, as reported by the Dartmouth Atlas data on Medicare Prescription Drug Utilization.

Category 4: Health care cost

4.3 Unit cost

Commercial reimbursement per CPT: Index of payment for 100 most-common physician office-based procedures: Composite index computed based on top 100 most-common CPT procedure codes rendered in the doctors' offices in 2012; analysis is based on 2010–2012 Truven Commercial Dataset

Commercial reimbursement per DRG: Index of payment for 100 most-common DRG discharges: Composite index computed based on top 100 most common DRG discharges in 2012; analysis is based on 2010–2012 Truven Commercial Dataset.

Cost per acute inpatient admission: Cost per acute inpatient admission is adjusted for age and gender; analysis is based on 2010–2012 Truven Commercial Dataset.

Medicare Inpatient Prospective Payment System (IPPS) Geographic Adjustment Factor (GAF) (average of urban area-level weighted by Medicare discharges): Linked hospital-level Medicare discharge information to MSA-specific GAF to construct weighted average at the state level.

Weighted average Medicare reimbursement per DRG: Composite index computed based on the top 100 most-common DRG discharges, updated to include 2012 figures released by CMS on June 2, 2014.

Category 5: Status of health care reform efforts

5.1 Health Information Technology

Percentage of office-based physicians using EMR/EHR: Percent of surveyed physicians that reported having a Basic EMR system in place on the DCD's National Ambulatory Medical Care Survey, Electronic Health Records Survey. A Basic EMR system is defined as a system that has all of the following functionalities: patient history and demographics, patient problem lists, physician clinical notes, comprehensive list of patients' medications and allergies, computerized orders for prescriptions, and ability to view laboratory and imaging results electronically.

Percent of physicians routing prescriptions electronically, Percent of community pharmacies e-prescribing-activated: Based on a total count of 522,000 office-based physicians in the U.S. per SK&A data. Surescripts' count of active-physician responses represents those ambulatory-care physicians who used electronic prescription routing within the last 30 days of 2013. For the calculation of active office-based physicians in 2013, Surescripts made a 15% adjustment to remove acute physicians that are e-prescribing.

Category 5: Status of health care reform efforts

5.2 System initiatives

Percent of primary care practices that are Patient-Centered Medical Home (PCMH)-certified: MN figure is based on MN definition of PCMH; national figure is based on % of PCMH-certified as NCQA PCMH Levels 1–3.

Percent Medicare FFS beneficiaries attributed to a Medicare ACO: Divided total count of fee-for-service beneficiaries attributed to Medicare ACOs by total Medicare FFS beneficiaries in the state, based on data from CMS Medicare Administrative files.

Bundled Payments for Care Improvement (BPCI): percent of eligible providers participating in program: Divided total count of BPCI participating providers by total count of providers that are

eligible for the program (from Medicare Provider of Service Files: Inpatient hospitals + Inpatient Rehab facilities + Home health agencies + Long-term care hospitals + Skilled Nursing Facilities).

Number of commercial and Medicare ACOs: Total count of commercial and Medicare ACOs, as identified through press searches by HealthQuest Publishers 2014 ACO Directory, current as of January 2014.

Number of Medicare ACOs: State-level counts of all Pioneer and Medicare Shared Savings Program ACOs, published by the Medicare ACO Program News and Announcements webpage. Current as of April 2014.

Category 5: Status of health care reform efforts

5.3 Medicaid expansion

Percent change Pre-Open Enrollment (Monthly Average) to July 2014: The percent change in Total Medicaid and CHIP Enrollment, from the Pre-Open Enrollment Monthly Average Medicaid and CHIP Enrollment (July–Sept 2013) to July 2014 among states reporting data for both periods. A negative percentage change may be due to a number of factors, including the preliminary nature of the monthly data (as described above) as compared with the finalized nature of the baseline data. Changes in enrollment levels are driven by the number of newly enrolled individuals as well as by the number of individuals whose coverage has terminated. Figures are based on data on Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports released by CMS as of September 22, 2014.

Percentage drop in uninsured (2010-2014): Based on respondents' self-reports of health insurance status when asked the questions, "Do you have health insurance coverage?" on the Gallup-Healthways mid-year Well-Being Index surveys for 2010 and 2014.

Category 5: Status of health care reform efforts

5.4 State health care exchanges

Latest marketplace QHP selection total as percent of non-elderly (0-64), non-Medicaid-eligible uninsured population: Total health insurance marketplace enrollment as of April 2014 as a percent of non-elderly, non-Medicaid eligible, uninsured population, based on data collected by the McKinsey Center for U.S. Reform.

Health insurance marketplace enrollment as a share of potential marketplace population: This metric reflects the number of 1) Individuals who have selected a marketplace plan as a percent of the 2) Estimated number of potential marketplace enrollees. 1) Individuals Who Have Selected a Marketplace Plan: Represent the total number of individuals who have been determined eligible to enroll in a plan through the Marketplace and who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer). 2) Estimated Number of Potential Marketplace Enrollees: Includes legally residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the federal poverty level who live in states that elected not to expand the Medicaid program; these individuals are not eligible for financial assistance and are unlikely to have the resources to purchase coverage in the Marketplace. Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014 and State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act, Kaiser Family Foundation, November 5, 2013.

Number of insurers in the individual health insurance marketplace: Count of private insurance companies that offer individual health insurance exchange products, based on data collected by the McKinsey Center for U.S. Health Reform from exchange websites.

Ratio of unique carriers on exchange: carriers in the individual market in 2012: Count of private insurance companies that offer individual health insurance exchange products compared with the number of health insurance companies offering individual health insurance products in 2012, based on data collected by the McKinsey Center for U.S. Health Reform from exchange websites and 2012 NAIC filings.

Product design: HMO and EPO products as % of all plans on the exchange: Count of Health Maintenance Organization and Exclusive Provider Organizations as a percent of all plans offered on the state health insurance exchange, based on data collected by the McKinsey Center for U.S. Health Reform from exchange websites.

Network design: Products with narrow networks as % of all plans on the exchange: Narrow networks are defined as having 30–69% of the 20 largest hospitals not participating in the insurance product's provider network. "Ultra-narrow" networks are defined as having at least 70% of the 20 largest hospitals not participating. Based on hospital network data compiled from 2014 individual exchange market products analyzed by the McKinsey Center for U.S. Health Reform.

Minimum price premium for a single 27-year old as % of average state income (Catastrophic, Bronze, Silver, Gold, Platinum): The premium for the least expensive health plan offered by metallic tier, based on data collected by the McKinsey Center for U.S. Health Reform from exchange websites, as a percent of average state income, based on data from the U.S. Census Bureau's American Community Survey.

2014 monthly premiums for a single 40-year old at 250% of FPL in a major city (Benchmark plan, Second-lowest-cost Silver plan after subsidies, Lowest-cost Bronze Plan before subsidies, Lowest-cost Bronze Plan after subsidies): Premium data for state-run exchanges were collected from health insurer rate filings submitted to state regulators, and from state exchange websites. Premium data for federally facilitated and partnership exchanges are available from the Department of Health and Human Services. These data were last updated on October 22, 2013.

Enrollment by metal tier (Catastrophic, Bronze, Silver, Gold, Platinum): Data represents cumulative Marketplace enrollment-related activity for October 1, 2013 to April 19, 2014. For each metric, the data represent the Total Number of Individuals Determined Eligible to Enroll in a Plan Through the Marketplace who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period, excluding plan selections with unknown data for a given metric. Special Enrollment Period (SEP) activity includes plan selections that were made between April 1, 2014, and April 19, 2014, by those who qualified for an SEP because they were "in line" on March 31, 2014, as well as those who experienced a qualifying life event or a complex situation related to applying for coverage in the Marketplace.

4. Calculation of state rank

State ranks are calculated at the category level and overall, across the five categories. Ranks are generated for all 50 states and the District of Columbia. Category ranks are calculated by taking the average state rank for each state across all normative metrics within the category. States are then force ranked from 1-51 based on their average. The overall state rank is generated by first taking the average of the state ranks for each state for each category (step 1, above), and then force ranking states from 1-51. The average is taken between categories rather than across all metrics in the scorecard to give each category equal weighting. This is necessary because there is significant variation in the number of normative metrics in each category.

CITATIONS

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2. For example, Minnesota placed first in the country in the Commonwealth Fund's overall ranking of state health systems in 2014. Radley et al., *Scorecard on State Health System Performance, 2014*, The Commonwealth Fund, April 30, 2014.
3. The same report ranked the Mayo Clinic first in the country on half of the 16 medical specialties evaluated. "U.S. News Best Hospitals 2014–15," *U.S. News & World Report*, July 15, 2014, (http://health.usnews.com/best-hospitals).
4. "Medicare Accountable Care Organization (ACO) Quality Reporting," Centers for Medicare and Medicaid Services (http://www.medicare.gov/physiciancompare/aco/search.html).
5. "New Report: Minnesota is 38th Most Obese State in the Nation," Trust for America's Health, July 7, 2011.
6. State Innovation Model Grant Application Materials: Project Narrative, Health Reform Minnesota, September 2012 (http://mn.gov/health-reform/SIM/).
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8. National Health Expenditure Data: Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, 1991–2009; *Minnesota Health Care Spending and Projects, 2012*, Minnesota Department of Health, June 2014.
9. "Minnesota's All Payer's Claims Database (APCD)," Minnesota Department of Health (http://www.health.state.mn.us/healthreform/allpayer/index.html).
10. "States Getting a Jump Start on Health Reform's Medicaid Expansion," Kaiser Family Foundation, April 2, 2012.
11. "State Marketplace Profiles: Minnesota," Kaiser Family Foundation, November 12, 2013.
12. These include: CMS Pioneer and Medicare Shared Savings ACO programs, Medicare Multi-payer Advanced Primary Practice demonstration, Bundled Payments for Care Improvement (BPCI), CMS Demonstration to Integrate Care for Dual Eligibles, Strong Start initiative, and the State Innovation Model (SIM) testing grant; see "Where Innovation is Happening: Minnesota," Centers for Medicare and Medicaid Services: Innovation Center (http://innovation.cms.gov/initiatives/map/index.html).
13. "Top Employers Statewide," Minnesota Department of Employment and Economic Development analysis of data from the *Minneapolis-St. Paul Business Journal*, 2011.
14. "Minnesota Health Care Industry Assessment," Minnesota Department of Employment and Economic Development analysis of data from the Labor Market Information Office, February 2011.
15. Normative measures are those for which it is possible to agree upon better and worse performance, for example, the percentage of the population that is uninsured. Descriptive measures convey important information, but are not subject to normative interpretation in the same way, for example, the percentage of the population that is covered though private insurance. Of the 154 total measures included in the scorecard, 82 have been classified as normative and are used to rank Minnesota against other states and the national average to provide a sense of relative performance.
16. HealthLeaders-Interstudy's analysis of data from the U.S. Census Bureau's "Small Area Health Insurance Estimates (SAHIE)," January 2014.

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20. Analysis of 2012 data in the Medicaid Benefits Database maintained by the Kaiser Commission on Medicaid and the Uninsured shows that Minnesota offered above-average benefit levels for nearly all of the 43 different individual medical services tracked; see "Medicaid & CHIP Indicators—Medicaid Benefits," Kaiser Family Foundation: Kaiser State Health Facts, 2012 (http://kff.org/state-category/medicaid-chip/medicaid-benefits/).
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31. The Hospital Safety Score uses 28 national performance measures from the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services to produce a single score representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors; see "Hospital Safety Score: How Safe is Your Local Hospital," Hospital Safety Score (http://www.hospitalsafetyscore.org/).

32. The National Immunization Survey (NIS) estimated vaccination coverage among children 19–35 months for the combined vaccination series known as 4:3:1:3*3:1:4 series, referred to as routine, that includes ≥4 doses of DTaP, ≥3 doses of poliovirus vaccine, ≥1 doses of measles vaccine, full series of Hib (3 or 4 doses, depending on product), ≥3 doses of HepB, ≥1 doses of varicella vaccine, and ≥4 doses of PCV.

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37. Based on Commercial claims data on the volume of office-based visits to specialists and primary care physicians, made available by Truven Analytics.

38. Weighted average Medicare reimbursement by state is calculated using Medicare claims data for the top 100 most-common DRG charges in 2012.

39. Composite index computed for the top 100 most common CPT procedure codes rendered in the doctor's office in 2012, based on commercial claims data made available by Truven Analytics.

40. The Health Care Incentives Improvement (HCI3) and the Catalyst for Payment Reform co-published a state report card on transparency of physician quality information in December 2013 that ranked Minnesota first in the nation on its progress in systematically collecting, reporting, and monitoring provider quality measures; see *State Report Card on Transparency of Physician Quality Information: HCI3 Improving Incentives Report*, Health Care Incentives Improvement Institute, December 2013.

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42. Based on HealthLeaders Interstudy estimates of the size of the Medicare fee-for-service population that were based on data they obtained directly from the Centers for Medicare and Medicaid Services and a count of Medicare ACOs from HealthQuest Publishers; see "Managed Market Survey-Rx," HealthLeaders InterStudy, January 2014; Accountable Care Directory, 2014 edition, HealthQuest Publishers, January 2014.

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45. Only ~4% of providers eligible for Medicare's Bundled Payments for Care Improvement (BPCI) have participated in the program, compared with ~10% of providers nationally. Eligible providers were identified and counted from the Medicare Provider of Service files and defined by the BPCI program webpage to include: inpatient hospitals, inpatient rehabilitation facilities, home health agencies, long-term care hospitals, and skilled nursing facilities; see "Provider of Service Files," Centers for Medicare and Medicaid Services, May 7, 2014 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html); "Bundled Payments for Care Improvement (BPCI) Initiative: General Information," Centers for Medicare and Medicaid Services, 2014 (http://innovation.cms.gov/initiatives/bundled-payments/).

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47. Based on analysis of exchange filings by the McKinsey Center for U.S. Health Reform.

48. PreferredOne, the insurance company with the lowest rates and most customers on MNsure, announced on September 16, 2014, that it will be pulling out of the state health insurance exchange. This decision is expected to increase the average premium for consumers during the 2015 Open Enrollment period. As of August 6, PreferredOne had 59% of the MNsure individual market; see "Politicians Weigh in as MNsure's Largest Insurer Drops Out," September 16, 2014; "PreferredOne drops out of MNsure exchange," KARE 11 News, September 16, 2014.

49. Seventeen percent of the non-elderly (0–64), non-Medicaid eligible uninsured population had enrolled in exchange products in Minnesota, compared with 29% nationally, based on insights by the McKinsey Center for U.S. Health Reform.

50. Percent change in monthly Medicaid enrollment (compared with pre-Open Enrollment) in Minnesota was 20.6% as of July 2014, while the national average was 13.6%, according the McKinsey Center for U.S. Health Reform. It should be noted that a substantial portion of members enrolled through MNsure are enrolling in Medical Assistance or MNCare.

51. The District of Columbia has Medicaid eligibility levels of 221% and 215% of FPL for Parents of Dependent Children and Other Non-disabled Adults respectively, according to the Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid Statistical Information Systems data; see "Medicaid & CHIP Indicators—Medicaid/CHIP Eligibility Limits, 2014," Kaiser Family Foundation: Kaiser State Health Facts, April 1, 2014 (http://kff.org/state-category/medicaid-chip/).

52. In 2003, MN Community Measurement developed a new approach to reporting five key components in one "all-or-none" diabetes care composite measure "Optimal Diabetes Care." HealthPartners developed a Total Cost of Care (TCOC) measure and a Total Care Relative Resource Value (TCRRV) measure, which received the NQF's first-ever endorsements of full-population TCOC measurement approach in January 2012. See "Our Story," Minnesota Community Measurement (http://mncm.org/about-us/our-story/); "Total Cost of Care," HealthPartners (https://www.healthpartners.com/tcoc).

53. The rate of direct hospital employment physicians is slightly lower (24%) than the national average (25%), partly because of state legal rulings that limit physician employment to nonprofit organizations. A 1955 Minnesota Attorney General Opinion stated that a nonprofit corporation was permitted to contract with physicians to provide medical services to patients. Although Minnesota Statue § 147.081 prohibits the "unlicensed" practice of medicine, it does not explicitly prohibit the corporate practice of medicine. See "Physician List," SK&A, May 2014 (http://www.skainfo.com/physician-mailing-lists.php); "Recent District Court Case Highlights State Variation in Applying Corporate Practice of Medicine and Global Billing Restrictions to MRI Providers," Eptein Becker & Green, P.C., May 6, 2014.

54. Minnesota also has a Medicaid ACO demonstration that includes nine providers and covers 145,000 beneficiaries. This Medicaid ACO serves as the foundation for the Minnesota SIM Accountable Care Health Model. See "State Innovation Model Grant – Minnesota Accountable Health Model," Health Reform Minnesota, July, 2014 (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home).

55. The state's key programs include Minnesota Senior Health Options (MHSO), Special Needs BasicCare, and the Medicare Advantage Dual Eligible Special Needs Plans (MA D-SNP). These programs have readied the state to be an active participant and front-runner to receive federal funding through CMS demonstration programs that focus on this population. Minnesota received $1M through CMS's Demonstration to Integrate Care for Dual Eligibles in 2011, 1 of 15 states to receive program funding. It then went on to become 1 of 9 states to receive CMS approval to implement a demonstration to integrate care and align administrative functions for dual eligibles for three years that began in September 2013. MN plans to use this demonstration to combine existing initiatives, such as Medicaid Health Care Homes, to better care for this at-risk population. See Minnesota Department of Human Services (http://mn.gov/dhs/); Musumeci, MaryBeth, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," Kaiser Family Foundation, July 24, 2013.

56. In 2011, after HMOs reported strong profits of 7.9% from managed Medicaid products in 2010, the state urged the four largest Medicaid health plans to limit their net income for MA and MNCare to 1% and instituted a competitive bidding process for managed Medicaid contracts. The state funded a Legislative Auditor to contract with outside firms to perform independent audits of the Medicaid health plans. It is projected that these new contracts will yield savings of ~$600M by the end of 2013.

57. The Minnesota 2008 Health Care Reform Act required that all Medicaid and CHIP enrollees have access to health care homes, designed to provide a greater extent of care coordination to beneficiaries in order to reduce acute care costs. And, starting in 2013, six ACOs have entered into shared savings and risk agreements with the Medicaid program, creating additional opportunities for the program to produce savings through lower utilization and better quality of care. See Jennifer N. Edwards, "Health Care Payment and Delivery Reform in Minnesota Medicaid," The Commonwealth Fund, March 2013.

58. The suicide prevention program under MDH's Injury and Violence Prevention Unit, for example, uses a public health approach to preventing suicides by supporting and coordinating state-funded suicide prevention activities and providing technical assistance and data to support community-based programs. MDH also has a number of initiatives targeting specific at-risk populations, such as the Refugee Health Resource Group and the Center for Victims of Torture. See "Violence Prevention," Minnesota Department of Health (http://www.health.state.mn.us/injury/topic/topic.cfm?gcTopic=7).
59. *Centers for Disease Control and Prevention (CDC): Behavioral Risk Factor Surveillance System Survey Data*, Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009–2012.
60. Although rates of preventive screening and immunization in adults are better than the national average, the rate of childhood immunization is worse, at 78%, compared with 83% nationally, in 2013.
61. The 2008 Health Care Reform Act created the Statewide Health Improvement Program (SHIP), which coordinates programs with local communities through its Office of Statewide Health Improvement Initiatives across a number of focus areas: tobacco, obesity, nutrition, physical activity, farm-to-school food, safe routes to school, school health, and school meals. MDH has also issued new immunization laws for schools, child care, and, for the first time, early childhood programs to begin September 2014. See "Statewide Health Improvement," Health Reform Minnesota (http://mn.gov/health-reform/topics/prevention/statewide-health-improvement/); "New Immunization Laws for Schools, Child Care, and Early Childhood Programs Begin September 2014," Minnesota Department of Health, August 1, 2014 (http://www.health.state.mn.us/divs/idepc/immunize/immrule/newlawfs.html).
62. Although the statewide child poverty rate is just 15%, this rate varies greatly by race: white (9%), African American (46%), Asian (23%), American Indian (49%), and Hispanic (30%). MN has the highest rate of Asian children living in poverty. Additionally, 26% of all immigrant children are living in poverty. See *Minnesota Kids County 2013: A data visualization of child well-being*, Children's Defense Fund, April 2013.
63. As defined by the State Community Health Services Advisory Committees (SCHSAC). See "SCHSRAC Regions with Community Health Boards," Minnesota Department of Health, May 2014 (http://www.health.state.mn.us/divs/opi/pm/schsac/docs/ataglance_schsac.pdf).
64. Note that we don't look at progress with implementation of reform.
65. As of December 2013, 322 primary care clinics—roughly 43% of the total in the state—had been certified as Health Care Homes. Nearly two-thirds of these are submitting claims for care coordination payments. Pilots for community care teams have been tested in three communities, and a series of tools and knowledge-sharing programs have been developed. See *Health Care Homes: Annual Report on Implementation: Report to the Minnesota Legislature 2012–2013*, Minnesota Department of Health: Health Reform Minnesota, January 2014.
66. Publicly sourced SHIP funding was reduced by 70% in the fiscal year 2012–13. CDC funding to local communities is being reduced due to national funding reductions, and is set to end in September 2014. See *The Minnesota Statewide Health Improvement Program—Progress Brief—Year 2*, Minnesota Department of Health: Health Reform Minnesota, March 2, 2012; "Community Transformation Grant," Minnesota Department of Health, May 29, 2014 (https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=minnesota%20community%20transformation%20grant).

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