Minnesota SIM Initiative

Award
$45 million

Period of performance
October 1, 2013 to December 31, 2017

Pre-SIM Landscape

**Minneapolis eHealth Initiative**
Funding issued for eHealth in 2006; EHRs widely adopted by 2013.

**2008 Health Reform Law**
Established 1) the HCH model, 2) the predecessor to the IHP model, and 3) the State Health Improvement Plan that laid initial ACH groundwork.

**Health Care Homes**
The State established HCHs in 2008 and implemented a certification process in 2010.

**Reimbursement of Emerging Professions**

**Other Investments in Reform**
Expanded Medicaid benefits for adults, launched Medicare ACO models, and had other CMMI awards in place.

Strategies

Symbols represent strategies that build on efforts that pre-date SIM.

**Pursue payment reform**
Minnesota facilitated successful participation in value-based purchasing models by a broad range of providers, with a focus on expanded participation in IHPs.

**Bolster health IT and data analytics**
The State issued grants to increase exchange of health information and effective use of data analytics, and addressed provider privacy and security concerns.

**Pursue delivery system reform**
Minnesota funded workforce development, engaged priority settings in ACHs, and expanded HCH participation. Reforms were inclusive of small and rural providers.

Reach

as of December 2017

More than half (58%) of Minnesota's total Medicaid population was served by the state's IHP model.

Integrated Health Partnership

**Medicaid**
58% of state population

**Statewide**
70%

Health Care Home

ACH = Accountable Community for Health; ACO = accountable care organization; CMMI = Center for Medicare & Medicaid Innovation; EHR = electronic health record; HCH = health care home; IHP = Integrated Health Partnership
**Impact on Medicaid Population**

### Goals

- **Better Care Coordination**
- **Increased Quality of Care**
- **Appropriate Utilization of Services**
- **Lower Total Spending**

### Integrated Health Partnership

<table>
<thead>
<tr>
<th>Goal</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Specialty provider visits</td>
<td>Relative improvement to CG</td>
</tr>
<tr>
<td>14-day follow up after inpatient admission</td>
<td>No improvement relative to CG</td>
</tr>
<tr>
<td>HbA1c testing</td>
<td>Relative improvement to CG</td>
</tr>
<tr>
<td>Improvements in HbA1c testing rates were expected, given the model focus, confirming that focused incentives can yield improvements.</td>
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<tr>
<td>Primary care provider visit</td>
<td>No improvement relative to CG</td>
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<tr>
<td>Though not the expected finding, given other positive findings, the decreased PCP visit rate may reflect effective coordination outside the traditional office setting.</td>
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<tr>
<td>ED visits</td>
<td>No improvement relative to CG</td>
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<tr>
<td>30-day readmissions</td>
<td>No statistically significant change</td>
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<tr>
<td>Professional PBPM spending</td>
<td>No statistically significant change</td>
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<tr>
<td>Facility PBPM spending</td>
<td>No statistically significant change</td>
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<tr>
<td>Total medical PBPM spending</td>
<td>No statistically significant change</td>
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### Limitations

Minnesota used SIM funds to support a broad range of innovations, which may reduce the measurable effects of IHPs because of contamination of the comparison groups. Accordingly, the estimated effects represented here are conservative estimates. Even so, they represent a more realistic view of the impact the IHP model given that multiple health reforms are happening simultaneously in the state.

### Lessons Learned

- Successful collaboration between the two state agencies that led the SIM Initiative was key to making progress.
- Defining accountable care through the Continuum of Accountability Matrix was critical to expanding accountable care models.
- Clearly outlining roles and responsibilities was key to successfully integrating emerging professions.
- A successful balance between spreading funding across many providers and “stacking” grants to a single provider can help spur progress in providers’ transformation.

**Notes:**

- CG = comparison group; ED = emergency department; IHP = Integrated Health Partnership; PBPM = per beneficiary per month; PCP = primary care provider

*We used Medicaid claims data from CMS MAX and Alpha-MAX research files to estimate IHP impact on care coordination, quality, and utilization while we used Medicaid data from the Minnesota All Payer Claims Database to estimate impact on spending.*