MINNESOTA'S VISION | HCH Health Care Homes
A Better State of Health

February 2010

What is a health care home?

A health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals a chronic or complex health conditions.

The development of health care homes in Minnesota is driven by the Institute for Healthcare Improvement's Triple Aim, an initiative to simultaneously achieve the following goals:

- Improve the individual experience of care.
- Improve the health of the population.
- Improve affordability by containing the per capita cost of providing care.

Background

2007: Minnesota passed first "medical home" legislation, called "provider directed care coordination," for patients with complex illness in the Medicaid fee-for-service population. (This is now called "primary care coordination".) More information is online at www.dhs.state.mn.us/primarycarecoordination.

The Governor's Health Care Transformation Taskforce and Legislature's Health Care Access Commission both endorse medical homes.

2008: Health care reform legislation requires "health care homes" for all Medicaid, SCHIP, state employees and privately insured Minnesotans (statute 256B.0751 and 62U.03).

The Minnesota approach to health care homes

The Health Care Home is a transformative change in the delivery of primary care. The design principles for health care home in Minnesota focus broadly on the continuum of "health" and incorporate expectations for engagement of the patient, family and community. Fundamentally, health care home is a change in the patient-provider relationship augmented by financial structures and measurement of results. Expectations for transformative change must be sufficient to achieve these results. Among these expectations are:

- **Patient- and family-centered care** will be foundational to the Minnesota Health Care Home program. Patients/families/consumers will be involved in all aspects of program development.

- **Quality improvement teams** will be required at the practice level. A health care home will have an active practice-based quality improvement team that includes patients/families as equal team members.
- Participation in a **learning collaborative** to support and foster practice-level change is required.
- **Financial structures** must be aligned to promote this transformation and must include adequate risk adjustment for medical and non-medical complexity.
- **Recertification** is based on outcomes. Minnesota will be moving to an outcomes-based system in its recertification of health care homes. In the certification and recertification process, a balance will be sought between fidelity to the model (criteria) and flexibility for innovation. A goal of the program is to maximize clinic flexibility to achieve all of the outcomes.

Steps in Health Care Home program development

Foundational components

- Outcomes recommendations
- Capacity assessment – clinic and public
- Patient/family/consumer council
- Resource and Education Committee

Program components

- Certification criteria
- Certification and recertification process
- Payment methodology
- Learning collaborative
- Outcome measurement

Progress to date and upcoming activities

Foundational components

Building on local and national experiences, work is collaboratively organized by state government between the state departments of health and human services, with a strong emphasis on public-private collaboration. Work is being completed through a combination of grant contracts and state-organized processes.

- **Outcomes recommendations.** Outcomes were developed by a collaborative group lead by the Institute for Clinical Systems Improvement. Developed at the onset of the program, these

outcomes will guide the development of specific measures. More information is online at: www.icsi.org/health_care_redesign_/health_care_home_/health_care_home_outcomes_reports.

- **Capacity assessment**. A consortium of Minnesota primary care associations received a contract to do a capacity and readiness assessment. The assessment was completed June 2009. Of Minesota's 707 primary care clinics, 53% responded. In that group 73% self reported that they had some components of HCH in place. More information is online at www.health.state.mn.us/healthreform/homes/capacity.
- **Patient / family/ consumer council.** The council will support involvement by patients, families, and consumers in all aspects of health care home development. The council includes members from or advocating for all ages, many disease-specific groups, and cultures. The council meets independently and participates in other health care home groups.
- **Resource and Education committee**

Program components

Health care home criteria

- Criteria were developed through a process that included open public meetings, facilitated discussions, and expert input, involving patients, families, and all sectors of the health care community. Minnesota collaborated with leading national criteria/standards organizations. Materials from this development process are online at http://www.health.state.mn.us/healthreform/homes/standards/proposedrule.html
- Recommendations for health care home certification standards were presented to the Commissioners of Health and Human Services in early February. There are five standards with measureable criteria that support each standard. The major categories for standards include:
  - Access / communication
  - Patient tracking and registry functions
  - Care coordination
  - Care plans
  - Performance reporting and quality improvement.
- Governor Tim Pawlenty signed the rule in January 2010

Certification and recertification process

Process workgroup is developing tools and processes to include in the initial certification site visits. Recertification requires the demonstration of progress towards Health Care Home outcomes.

Initial steps in the verification process with consistent language in the form of standards and criteria in the HCH rule for certification that all types of clinics, in all areas of the State have been developed. The HCH certification process design, an online web-based program, is under

development and as of February 18, 2010, MDH has received requests for access to submit a letter of intent and submitted letters of intent from clinics, clinicians, and health systems across the State representing approximately 500 providers.

Payment methodology

Legislative requirement for Care Coordination Payment

256B.0753

- DHS and MDH develop a system of per-person care coordination payments to certified HCHs by January 1, 2010
- Fees vary by thresholds of patient complexity
- Agencies consider feasibility of including non-medical complexity information
- Implemented for all public program enrollees by July 1, 2010

62U.03

- Health plans include HCHs in their provider networks by January 1, 2010 and make care coordination payments by July 1, 2010. Payment conditions and terms shall be developed "in a manner that is consistent with" the system under 256B.0753

A payment methodology steering committee has met over the second half of 2009. Payment methodology is completed and will be presented in a public meeting on March 12. A payment methodology technical development contract has been granted to the University Of Minnesota School Of Public Health.

Payment methodology subgroups included:

- Clinic and health plan processes for health care home payment
- Patient risk stratification and payment architecture
- Consumer/patient payment considerations.

Payment principles:

- Care coordination payment will reflect the patient's medical complexity, and will evolve toward reflecting "supplemental" complexity such as limited English-language skills, cultural differences, and other barriers to health care.
- Providers will prospectively self-identify patients eligible for care coordination payments, using a common method across payers that includes information on medical and non-medical complexity.

- Care coordination services will be coded consistently across practices and payers, fostering uniformity in definitions of the duration of service, level of patient complexity, etc.
- Stakeholders will establish a common minimum threshold of complexity for which patients are initially eligible for care coordination payment.
- Gate keeping (limiting services via primary care solely as a cost containment mechanism) is inconsistent with the health care home model. However, health care home providers will be accountable for outcomes related to health, patient experience, and cost.
- Improvement in outcomes related to health, patient experience, and cost as commonly agreed-upon will be required for continued certification as a health care home
- Payment methodology will be collaboratively refined and will evolve over time.

Payment methodology components

- Four paid tiers based on patient complexity
- First paid tier begins with patients with one major chronic or complex condition that is severe, persistent, and requires a care team. A tier below this threshold will not be paid at this time.
- Approximately 50% of MHCP program participants in the fee for service program are estimated to have conditions that will qualify for payment.
- Providers caring for patients/ families with either or both of two supplemental factors, non-English as primary language and presence of a significant mental illness in the patient or primary care giver, will receive a supplemental increase to reflect the added complexity associated with this care coordination.
- Providers will bill for the coordination of care at regular intervals (proposed monthly) via the normal billing and coding system.
- An audit system to monitor and understand coding practices against existing diagnoses in the claims system will identify patterns in tier assignment and flag potential outliers for review and assistance.

Learning collaborative

- Wilder research has completed a contract to report on learning collaborative research and implementation models.
  http://www.health.state.mn.us/healthreform/homes/collaborative/index.html
- Eleven key recommendations

  1. Prioritize patient and family involvement
  2. Ensure ongoing state leadership for Health Care Home
  3. Engage clinic leadership
  4. Incorporate principles of adult learning
  5. Use a change package framework
  6. Develop Learning collaborative sessions based on lessons learned nationally and locally
  7. Develop learning materials
  8. Provide technical assistance or team facilitation
  9. Develop a regional strategy
  10. Use data
  11. Understand the importance of culture change

Outcome measures
The Health Care Homes Outcomes Measurement Advisory Workgroup began meeting in August 2009. The purpose of this workgroup is to recommend a decision-making process for measuring health care home improvement in the areas of patient health, patient experience and cost-effectiveness. An Outcomes Measurement Technical Advisory Team will review individual measures for recommendation to the Advisory Group. Individual measures will be consistent with the recommendations of the ICSI HCH outcomes report.

National considerations

CMS announced this fall the development of an Advanced Primary Care (medical home) demonstration program for Medicare.

Intention is for Medicare to join existing state-led multi-payer medical home initiatives, with a focus on:
- Substantial support from primary care physicians
- Rigorous standards for practice qualification
- Integration of community resources

- Prospective assurance of budget neutrality

Application is due out in 2010. Minnesota is uniquely positioned and intends to apply. Collaborative input into this application will be sought.

MINNESOTA'S VISION
A Better State of Health
HCH
Health Care Homes

Contacts

Marie Maes-Vories
Program Manager, Health Care Homes
Minnesota Department of Health
Direct: (651) 201-3626
Fax: (651) 215-8915
Marie.Maes-Vories@state.mn.us

Pat Adams
Assistant Commissioner
Minnesota Department of Health
Direct: (651) 201-5809
Fax: (651) 201-4986
Patricia.Adams@state.mn.us

Ross Owen
Team Lead, Care Coordination
Minnesota Department of Human Services
Direct: (651) 431-4228
Fax: (651) 431-7420
Ross.Owen@state.mn.us

Jeff Schiff
Medical Director
Minnesota Department of Human Services
Direct: (651) 431-2479
Fax: (651) 431-7420
Jeff.Schiff@state.mn.us

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Department of Human Services

www.health.state.mn.us/healthreform