Health Care Homes: Annual Report on Implementation

Report to the Minnesota Legislature 2009

Minnesota Department of Health
Minnesota Department of Human Services

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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Executive Summary

Health care homes, also nationally known as medical homes, are an important component of a primary care cornerstone in Minnesota's comprehensive, nation-leading 2008 health reform legislation, signed into law by Gov. Tim Pawlenty. The health care home (HCH) is a transformative change in the delivery of primary care. It is not a place, but a philosophy. It offers a model where patients and families are at the center of care – and the right care is provided at the right time, in the right place. It is a partnership where patients and families can develop a stronger relationship with their care team, leading to better health and quality of life. It develops proactive approaches through care plans and offers more continuity of care through increased care coordination between providers and community resources.

Health care homes are an important component of the package of reforms that make up Minnesota's Vision for a Better State of Health. This is a set of building blocks that lead toward significant payment reforms and care redesign. As part of Minnesota's Vision, the development of health care homes in Minnesota is driven by the Institute for Healthcare Improvement's Triple Aim. The triple aim calls for simultaneously improving the individual experience of care, the health of the population and the affordability of health care.

Minnesota's Vision for Health Care Homes focuses on a broad continuum of health. The health care home model also provides concrete steps that clinics and clinicians can take to redesign their practices, in order to improve the health of their patients and the efficiency of their clinics. Health care homes will be evaluated based on the health outcomes of patients, as well as the experience of patients and the cost-effectiveness of care.

Activities and accomplishments. Over the past year and a half, the Minnesota Department of Health (MDH) and Department of Human Services (DHS) have worked to build the foundation of health care homes in Minnesota, as required by law. Program development focused on the creation and development of:

1. A capacity assessment
2. Certification standards
3. A certification process
4. Learning collaboratives
5. Outcomes measures
6. A payment methodology

1. Completion of capacity assessment. One of the first steps of implementation was to understand how ready Minnesota providers and patients are for health care homes. To that end, MDH contracted with a consortium of Minnesota primary care associations to perform a capacity and readiness assessment in the spring and summer of 2009. The final report showed that:

- The majority of responding Minnesota primary care clinics are preparing for health care home implementation.
- Consumers are somewhat aware of health care homes, but it is clear that more must be done to educate consumers about the concept.
- There is a considerable gap between clinic and consumer perspectives about current use of health care home components.

Next steps: Minnesota will continue to act on recommendations from the assessment.

2. Creation of certification standards. Building on state and national experiences with medical homes, care coordination and patient- and family-centered care, MDH and DHS led a robust community engagement process to gather input on the standards for certification as a health care home. That work was the foundation of the health care homes rule, which is organized around five thematic standards:

access and communication; participant registry and tracking participant care activity; care coordination; care plan; and performance reporting and quality improvement.
Next steps: Certification of health care homes based on standards set in rule language.

3. Development of certification process. MDH and DHS worked with a variety of stakeholders to develop the certification and verification process and have provided a variety of educational opportunities to inform clinics and clinicians about the certification process.
Next steps: Starting in January 2010, clinics and clinicians will be able to complete the application to become a health care home, and site visits will begin.

4. Creation of learning collaboratives. MDH and DHS contracted with researchers to evaluate and report on collaborative learning models. Two collaborative learning events took place in fall 2009, and an education and resources committee also was convened to further develop learning opportunities for clinics and clinicians.
Next steps: Minnesota is in the process of issuing a request for proposals to further develop the health care home learning collaborative based on what has been learned so far.

5. Development of outcomes measures. MDH and DHS contracted with the Institute for Clinical Systems Improvement (ICSI) to develop outcomes recommendations that informed the thinking behind the implementation of health care homes. A work group that will develop and monitor outcomes measures for health care homes began meeting in August 2009; part of its work will be to evaluate health care homes based on patient health outcomes, patient experience and care delivery costs.
Next steps: MDH and DHS will disseminate first-year outcomes and benchmarks for delivery. MDH and DHS will develop data submission processes and an evaluation methodology.

6. Development of payment methodology. MDH and DHS drew on the expertise of a steering committee and three work groups composed of a variety of stakeholders from across the health care system. Stakeholders made recommendations on provider processes, patient complexity tiers and impact on patients and families.
Next steps: Completion of development of payment methodology. Payments begin July 1, 2010.

Challenges. The implementation of the health care home model allows Minnesota the opportunity to improve existing health care practices, but these opportunities come with challenges:

- **Clinic readiness to begin HCH certification.** Some 73 percent of Minnesota primary care clinics self-report that they are working on the health care home transformation. Meeting HCH certification standards requires a clinic redesign, new approaches to patient care and tracking benchmarks. The scope of change is extensive, and many clinics are just beginning to understand that this transformation to a certified health care home requires epic, whole-practice redesign.
- **Consumer understanding of health care home concepts and benefits.** A capacity assessment of clinic and consumer readiness for health care homes revealed that consumers are only somewhat aware of the concept of health care homes. Moreover, there is a gap in perceptions between consumers and clinics. Consumers generally feel less involved/included in their health care decision-making and clinic improvement than the rates reported by the clinics.
- **Development of payment methodology.** A number of challenges have been identified, each of which requires careful consideration of all sides of the issues.

Minnesota has been a leader in pursuing policies to improve the health care system. In developing health care homes in Minnesota, MDH and DHS have provided a model for public-private collaboration to advance the goals of improving health, value and patient experience. Additional details about health care homes in Minnesota can be found at http://www.health.state.mn.us/healthreform/homes/index.html.

Background

Health care homes, also nationally known as medical homes, are an important component of a primary care cornerstone in Minnesota's comprehensive, nation-leading 2008 health reform law. Health care homes (HCH) are an innovation in primary care in which providers, families and patients work in partnership to improve the health and quality of life for individuals, especially those with chronic and complex conditions. Minnesota has adopted the term "health care homes" rather than "medical homes" in order to indicate a broader focus on improved health care coordination, community involvement and prevention.

Health care homes put the patient and family at the center of their care, develop proactive approaches through care plans and offer more continuity of care through increased care coordination. The end goals are better health for patients and more effective and satisfying care delivery for providers.

As part of Minnesota's Vision for a Better State of Health, health care homes strive to achieve the goals of the Institute for Healthcare Improvement's Triple Aim[1]:

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

Medical home legislation was first passed by the Minnesota Legislature in 2007 and signed into law by Gov. Tim Pawlenty. This applied only to very complex fee-for-service public program enrollees. The broader 2008 health reform law includes provisions to develop health care homes, including the development of outcomes measurements, standards and criteria for certification and a payment methodology.

The 2008 law builds on the national momentum of the medical/health care home concept of transforming primary care delivery to achieve more patient- and family-centered care and improved value, in terms of cost and quality. The law allows clinics and clinicians to become certified as health care homes and patients to voluntarily enroll in health care homes to receive care. In a June 2009 report[2], the National Academy for State Health Policy identified Minnesota as one of 10 leading states in the advancement of health care homes**.**

The 2008 law represents one type of payment reform by creating a care coordination payment for health care homes. It aims to create critical mass by requiring that both publicly funded and private fully insured health care plans pay a care coordination fee for eligible complex patients in certified health care homes in state and health plan networks.

The Minnesota Department of Health (MDH) and Department of Human Services (DHS) are collaborating to implement the various aspects of health care homes in Minnesota.

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 homes in Minnesota focus broadly on the continuum of "health" and incorporate expectations for engagement of the patient, family and community. The aim is to improve the health and quality of life for Minnesotans, and to connect the health care delivery system with the community and broader goals of improving population health. To accomplish this transformation, MDH and DHS, in collaboration with private

[1] Institute for Healthcare Improvement. http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
[2] National Academy for State Health Policy. Building Medical Homes in State Medicaid and CHIP Programs, Commonwealth Fund, June 2009.

partners, have developed a set of broad expectations for health care homes in Minnesota. Several aspects make Minnesota's approach unique:

- Minnesota is using a transparent statewide implementation approach with significant **public-private community partnerships**. This approach has established the foundation for partnership and culture change.
- Clinics and clinicians must meet all of the requirements for **health care home certification.** These requirements, established in the health care homes rule, were created by MDH, DHS and community partners. Efforts were made to ensure that all types of clinics, in all areas of the state can achieve these standards and criteria.
- **Patient- and family-centered care** is foundational to health care homes in Minnesota. Patients/families/consumers have been involved in all aspects of program development. As part of this, a **Consumer and Family Council** has been created whose charge is to advise the health care home implementation and participate in advisory work groups. The council began meeting in November 2008, and members from this council have served on each of the health care home work groups and committees that have worked on implementation of the 2008 health care homes law.
- **Clinical health care teams** include patients and families, who work in partnership with the clinical team to plan and coordinate their care. Clinical team members work at the "top of their license" in order to provide a coordinated, efficient approach to care delivery.
- **Quality improvement teams** are required at the practice level. A health care home must have an active practice-based quality improvement team that includes patients/families as equal team members.
- Health care homes must participate in the state-defined **learning collaboratives** that support and foster practice-level change. Minnesota is building upon the successful learning collaborative for children with special health care needs. Two collaborative learning events were held in 2009 to include more participants from across the state who wanted to learn about the health care home initiative.
- **Financial structures** must be aligned to promote this transformation and must include risk adjustment for medical and non-medical complexity. A successful certification program includes a payment methodology that is developed with payers, clinicians and consumers.
- **Recertification** is based on outcomes. There is a strong commitment by MDH, DHS and community partners to improve the health outcomes for the citizens of Minnesota by tying the measurement of outcomes to continued recertification. A work group is developing the beginning outcomes measures. 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.
- The legislative requirement to establish an interoperable electronic health records by 2015 will support the **technology requirements** for health care homes.
- MDH and DHS have worked to link health care homes with the other buildings blocks that are part of **Minnesota's Vision** and the 2008 health care reform components.

Health Care Home Program Development

The statewide implementation of health care homes is collaboratively organized in state government between DHS and MDH. The agencies have emphasized public-private collaboration and transparency with patients and families, the health care community and other organizations.

Work has been completed by MDH and DHS staff, as well as through grant contracts. MDH and DHS have been mindful of the need for integration with other parts of the health care reform law.

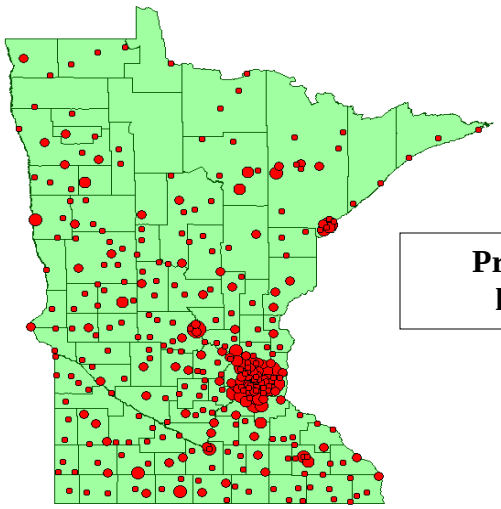
Completion of capacity assessment. To understand how ready Minnesota providers and patients are for health care homes, MDH contracted with a consortium of Minnesota primary care associations to perform a capacity and readiness assessment in the spring and summer of 2009.

The health care home capacity assessment[3] was completed by the Minnesota Chapter of the American Academy of Pediatrics Foundation in partnership with the Minnesota Academy of Family Physicians (MAFP), the MAFP Foundation, the American College of Physicians-Minnesota Chapter and Stratis Health.

A total of 707 state-contracted primary care clinics were invited to participate in the primary care survey; 373 clinics completed the survey (a 53 percent response rate). Five focus groups were conducted statewide to solicit consumer input in addition to an online consumer survey. Questions related to health care access, experience in primary care clinics and knowledge of/interest in health care home concepts. Over 560 consumers statewide completed the survey.

Clinic highlights. Based on this assessment, the authors concluded that a majority of responding Minnesota primary care clinics are preparing for health care home implementation. The majority (272, or 73 percent) of primary care clinics that responded to the survey self-reported they had some of the health care home components already implemented in their clinic.

- More of the responding clinics that said they had already implemented some HCH components in their clinic are located in urban areas (76 percent) compared to rural areas (24 percent).
- Clinics that reported participating in the pediatric Minnesota Medical Home Learning Collaborative between 2004-2009 were more likely to have implemented some HCH components in their practices.
- Potential barriers to implementation include workforce and staffing shortages and start-up costs:
    - Nearly 62 percent of the clinics indicated that workforce shortages or staff time are a possible barrier to implementing HCHs.
    - More than 70 percent of Minnesota clinics identified start-up and/or organizing costs as a possible barrier.



Primary care clinic locations in MN

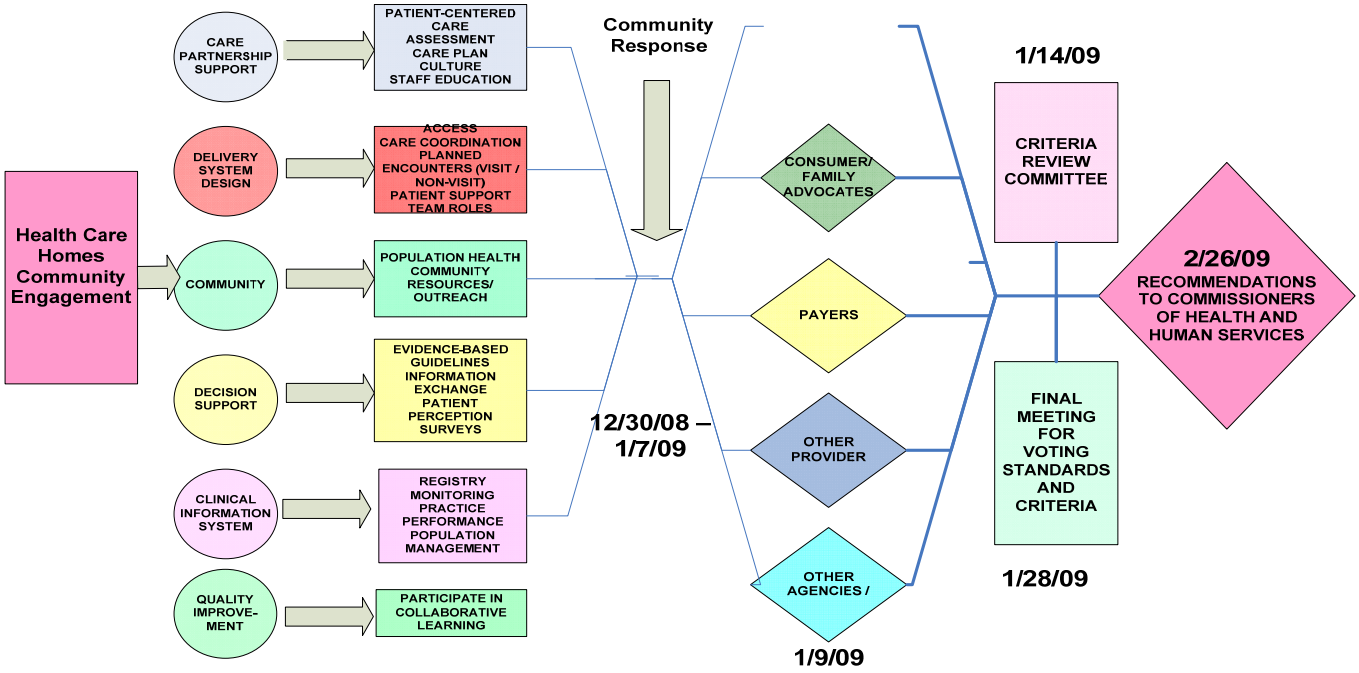
[3] Minnesota Chapter of the American Academy of Pediatrics. Minnesota Health Care Home Capacity Assessment: Clinics and consumers identify their readiness for health care reform and health care home implementation, June 30, 2009. http://www.health.state.mn.us/healthreform/homes/capacity/HCHCapacityAssessmentReport.pdf

Consumer highlights. Consumers are somewhat aware of the health care home concept and have identified one key issue to be communication with their primary care providers.

The consumer perception of care provided by their clinic compared to the responses from primary care clinics provided an interesting contrast. Consumers generally feel less involved/included in their health care decision-making and clinic improvement than the rates reported by the clinics in the clinic survey.

Creation of certification standards. To develop the health care home standards and criteria, Minnesota used a robust community engagement and input process. This work, completed in late 2008 and early 2009, was based on scientific evidence and national models and gathered input from a wide array of stakeholders. Figure 1 illustrates the community engagement process and timetable for the completion of the recommendations.

Figure 1: Community Engagement Process



In December 2008 and January 2009, MDH and DHS hosted six public meetings to develop the health care home standards and criteria. About 120 people attended the community kick-off event in December 2008, and about 60 stakeholders participated in two subsequent work group sessions to help craft the standards and criteria for health care homes in Minnesota. These stakeholders included representatives from Minnesota health plan companies, health care providers and associations, physician organizations, individual physicians, governmental agencies, patient advocates, patients and family members. Additional meetings solicited further feedback from stakeholders to refine the proposed certification standards.

In developing the standards, a major goal was to start with the end in mind and begin with recommendations for outcomes. Following a request for proposals**,** MDH contracted with the Institute for Clinical Systems Improvement (ICSI) to make recommended health care home performance outcomes that MDH could use to evaluate applicants for health care home certification. ICSI assembled a large work group to perform this task. The work group sought input from 104 health care organizations or

professionals and compiled 523 comments on draft evaluative criteria. The work group also reviewed available evidence suggested by the comments.[4]

In addition to utilizing national research on the subject, national experts from the Center for Medicare and Medicaid Services[5], the National Committee for Quality Assurance[6], and the Center for Medical Home Improvement[7] also participated in community-wide dialogues and provided input on the Minnesota standards and criteria.

During the development phase of the standards and criteria, MDH and DHS sought further public input through a Web-based survey. MDH received input from 273 medical clinics, health care professionals and consumers. They provided data on the ability to implement each proposed requirement; the effect of the requirements on care delivery; and the requirements' impact on patient experience, patient health and cost of care.

> ***Development of the health care homes rule.*** Through this process, MDH and DHS developed five major categories that now make up the broad standards in the health care homes rule:
>
> - Access and communication
> - Participant registry and tracking participant care activity
> - Care coordination
> - Care plan
> - Performance reporting and quality improvement
>
> Seeking to gather as much public input as possible, MDH and DHS provided a draft rule to stakeholders in spring 2009 and asked for public comments prior to the publication of the proposed rule. Once the proposed rule was published in the State Register, MDH and DHS also collected public comments for 30 days. MDH carefully considered the written comments submitted during this period. Many comments came from provider organizations representing various sectors of the health care field, whose members will seek certification. MDH made changes suggested by the reviewers to clarify the requirements and make them more workable.
>
> The rule's main body contains detailed requirements that implement the five broad standards. Each standard has a set of requirements to address an applicant's particular circumstances, i.e., whether the applicant is seeking certification: (a) for the first time, (b) after one year of experience as a health care home or (c) after two or more years of experience. As the applicant moves along the experience continuum, these requirements focus more heavily on performance outcomes rather than the initial infrastructure. Finally, the rule contains procedural requirements, including provisions for a variance, revocation or voluntary certification surrender and an appeal when MDH declines to certify or recertify.

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[4] Institute for Clinical Systems Institute. Recommendations of Health Care System and Patient Outcomes to Consider in the Evaluation of Health Care Homes, 2008. http://www.health.state.mn.us/healthreform/homes/documents/HCH_ICSIOutcomesRecs.pdf

[5] CMS is an agency of the U.S. Dept of Health and Human Services and was formerly known as the Health Care Financing Administration. CMS developed a demonstration project for medical homes which is in the process of being carried out.

[6] The NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. It was founded in 1990. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it and how to promote improvement. The NCQA is a leading authority, if not *the* leading authority, on medical home criteria.

[7] The CMHI is an organization founded in 1993 by Dr. W. Carl Cooley, medical director, and Ms. Jeanne W. McAllister, B.S.N., M.S., M.H.A., director. The mission of the Center for Medical Home Improvement (CMHI) is to promote high quality primary care in the medical home and secure health policy changes critical to the future of primary care.

To see the full text of the adopted expedited permanent rule related to health care homes, please see http://www.health.state.mn.us/healthreform/homes/standards/proposedrule.html.

Development of Certification Process. To be eligible to be certified as a health care home, a clinician must be a physician, nurse practitioner or physician assistant who works as part of a team that takes responsibility for coordinating the whole spectrum of the patient's care. Clinicians must offer or coordinate a full range of primary care services, including first point of contact acute care, preventive care and chronic care.

Specialists who provide that full range of services can also apply to be certified as a health care home if they can demonstrate that they meet this requirement.

Individual providers or the clinic can be certified. An entire clinic can be certified, but each clinician must meet the requirements of certification.

The health care homes law and rule call for a statewide certification process. This process verifies that clinics are meeting the standards and criteria through an online assessment and site visit. To apply, candidates must complete:

- A letter of intent
- An application and self-assessment
- A site visit and document review

Initial process. The online application for HCH certification is under development, but the initial steps in the process have been available since fall 2009. Clinics that submit a letter of intent and apply for certification will complete a self-assessment and participate in a site visit as requirements for certification.

Site visits. The site visit plays a pivotal role in the HCH certification and recertification process. During this visit, evaluators will review information from multiple sources to determine the applicant's implementation of HCH standards. Two primary sources, interviews and documents will be used to elicit a comprehensive view of the applicant in addition to observation of the overall operation.

Certification conference calls. The health care home team began hosting monthly certification conference calls in November 2009, and conference calls and webinars are planned through mid-2010. These monthly calls address questions and answers relating to certification requirements and application procedures.

In addition, the health care homes program provides pre-certification training on an individual clinician or clinic level as interest arises. The health care homes team responds to questions through the health care homes e-mail account (health.healthcarehomes@state.mn.us), and on-site clinic training can be provided upon request.

Development of learning collaboratives. Minnesota has had a pediatric learning collaborative focused on building a medical home for special needs children since 2004. In 2009, two collaborative learning events were held which expanded the focus and the scope to the health care homes law. Currently, MDH and DHS are further developing a statewide learning collaborative to provide more opportunities for health care homes to share information and support each other. Health care homes are required to participate in the learning collaborative in order to be certified. Clinics and clinicians may also volunteer to participate in preparation for certification.

Research and evaluation of collaborative learning. The first step in the development process was an evaluation of collaborative learning methods and models that incorporate quality

improvement approaches that could be implemented statewide for initial and ongoing clinician certification as a health care home provider.

Wilder Research and national experts were awarded a contract to perform this research and evaluation and have completed a final report[8] on the project. The recommendations from this research will provide the basis for how the health care home learning collaborative will be designed and implemented.

The development of HCHs in Minnesota involves transforming complex systems. Change capacity varies significantly across the system. Transformation is not a short-term commitment; changes will be incremental. Based on the literature scan, interviews with experts and knowledge of the field, the researchers made 11 key recommendations.

Collaborative Learning Activities. Several collaborative learning opportunities for clinics have been put in place beginning in September 2009.

- **Sept. 12, 2009**: Workshop focused on care coordination in a health care home.
- **Oct. 26-29, 2009:** Health care home program sponsored multi-disciplinary clinic teams to attend an intensive training conducted by the Institute for Family-Centered Care, an internationally recognized organization focused on patient- and family-centered care.
- **Oct. 29-30, 2009:** Over 250 people attended a two-day State-sponsored collaborative learning event focused on various aspects of health care home implementation, including the certification process, identifying patients and developing registries, implementing quality improvement at a practice level, clinic culture change, implementing health care home at a system level and engaging patients as partners.

The health care home team will continue to host collaborative learning events across the state.

Health Care Home Resource and Education Committee. Additional educational resources have been developed by the health care home resource and education committee, which convened in August 2009. The work of this committee began with the review of numerous materials available through multiple state and national organizations related to medical home. This material was compiled as a resource guide for clinics and primary clinicians about the background of health care homes and how to get started implementing these concepts. This resource guide[9] was published on the health care home Web site in September 2009.

Development of Outcomes Measures. One of the principles that has guided the implementation of health care homes is to start with the end in mind and consider what should be measured and evaluated from the beginning. To that end, the process began with ICSI's recommendations for health care home outcomes, as referenced earlier in this report.

Health Care Homes Outcomes Measurement Advisory Work Group. An advisory group on health care home outcomes measurement began meeting in August 2009. The purpose of this work group is to recommend outcomes for measuring health care home improvement in the areas of patient health, patient experience and cost-effectiveness. This work group is working on the operational structure based on the rule and with a focus on population measurement risk

[8] Wilder Research. Integrating Best Practices into Collaborative Learning Methods for Health Care Home Providers, September 2009.
http://www.health.state.mn.us/healthreform/homes/collaborative/CollaborativeLearningEvaluation.pdf

[9] MDH Health Care Homes Education and Resources.
http://www.health.state.mn.us/healthreform/homes/education/index.html

adjustment for outcomes measures and measurement over time. Measurement will also evaluate progress toward decreasing disparities and will be coordinated with other measurements of disparities. Whenever possible, MDH and DHS will also coordinate with other health care reform measures that are being done for market transparency and quality reporting.

This work group will closely monitor the measurement and evaluation of health care homes. The group will meet for two years to follow the progress from implementation to evaluation for both recertification and outcomes measurement.

Evaluation of Health Care Homes Certification. The 2008 law requires HCHs to evaluate the effectiveness of HCH implementation at year three and year five. It is important to recognize that evaluations do not just pertain to documenting the effects of a program, but also to understanding the issues and factors that went into its development and implementation – and how and why the program is working.

Development of Payment Methodology. The health care homes law calls for the creation of a per-person, risk-adjusted system of care coordination payments to be developed by January 2010, and implemented in Minnesota Health Care Programs and applicable managed care products by July 2010. To develop this methodology, MDH and DHS drew on the expertise of a steering committee and three work groups composed of a variety of nominated stakeholders from across the health care system[10]. The stakeholder recommendations to the Commissioners will focus on the following areas:

- Design and instruction for processes by which providers and payers will identify patients and communicate for consistent and appropriate coding and billing of the care coordination payment.
- A series of patient complexity tiers for care coordination payment. Patients are placed in a tier based on the number of major conditions that impact their overall complexity and need for care coordination. Identified non-medical factors will enhance the payment rate at a defined percentage.
- Principles and recommendations for how the payment methodology should impact patients and families. These include the issues of cost sharing in private insurance, patient experience related to payment and data privacy.

This collaborative approach to designing the payment methodology is intended to create a multi-payer payment initiative that will reduce administrative burden, improve system-wide risk adjustment capacity, and achieve the necessary "critical mass" of reimbursement to drive the transformation of the primary care delivery system.

Challenges and Next Steps

Throughout the implementation process, MDH and DHS have discovered some important challenges to consider moving forward.

Clinic readiness to begin HCH certification. The certified health care home is designed to enhance the patient experience. Transformation of primary care practices to meet HCH certification standards requires physicians to adopt substantially different approaches to patient care. It is much more than a series of individual changes or adherence to clinical guidelines. It requires changes in infrastructure, culture and physician-patient relationships. Implementation costs can also be a challenge. A certified health care home requires the expansion to a proactive, population-based approach, especially for chronic care and preventive services. This transformation to a certified health care home requires whole-practice redesign.

[10] MDH Health Care Homes Payment Methodology.
http://www.health.state.mn.us/healthreform/homes/payment/index.html

In a recent study, 73 percent of Minnesota primary care clinics responding self-identified that they are working on health care home implementation and plan to seek certification. Yet 15 percent of clinics replied that they did not know about the certification.

Next steps: To have a successful certification program, MDH and DHS will work with community partners to provide technical support and opportunities for continued dialogue through the learning collaborative and other capacity building opportunities.

Consumer understanding of health care home concepts and benefits. There are significant challenges in the understanding of HCH concepts by consumers. The HCH capacity assessment survey revealed key areas to address for consumers:

- 52 percent agreed or strongly agreed that they understood the meaning of HCH.
- 42 percent were unsure of how a HCH would impact them and their health care.
- 38 percent thought a HCH would make it easier to see other specialists.
- 15 percent said a HCH would make no difference to them.
- 60 percent felt that a care plan would be helpful to them in managing their health care, but only 15 percent had a care plan, and 16 percent were unsure if they had one.
- The gap in perceptions between consumers and clinics is also considerable. While 95 percent of clinics said they included patients in decision-making about their care, only 76 percent of consumers agreed. Some 91 percent of clinics said they involved patients in clinic improvement, compared to 23 percent of consumers.

Next steps: MDH is working with the education and resource committee and the consumer and family council to establish marketing and communication plans that support consumers and clinics in the understanding of HCH benefits.

Payment Methodology Development. There has been significant engagement and response by a variety of stakeholders at all levels regarding the development of the payment methodology. Issues have been highlighted that require careful consideration.

Stakeholders have raised the question of whether the per-person care coordination fee that was identified in the law is the right model in the long term. Others have wondered how more provider risk-based models (such as accountable care organizations or global payments) can build on the foundation of health care home payments. A strong desire to preserve innovation and marketplace competition has been voiced throughout the process. Also important is building a multi-payer billing and coding process that minimizes administrative burden consistent with the recommendations of the Administrative Uniformity Committee. There have also been considerable challenges in the development of payment for work that is provided across time in our largely fee-for-service reimbursement structure, prompting stakeholders to recognize that payment systems must transform along with care delivery systems.

A number of questions and considerations have been discussed regarding the broad fiscal goals of health care homes. There is recognition that the concept of "cost neutrality" as described in the legislation can be differently interpreted and applied to patients, care systems, payers and/or the state budget. While there is broad agreement on the potential of health care homes to reduce costs while improving other outcomes, the financial implications for various stakeholders are not always clear. For example, there are considerable concerns regarding patients' out-of-pocket cost sharing liability, especially those who have high-deductible health plans, health reimbursement accounts or health savings accounts. In the ICSI DIAMOND implementation for patients with chronic depression, clinics noted that patients who needed to pay co-pays or co-insurance often dropped out of this care coordination program because of the cost, despite its demonstrated ability to improve outcomes.

Next steps: Stakeholders agree that the goal of the payment methodology is to achieve transformation of the primary care delivery system through a "critical mass" of payment at the practice level. There is

tremendous opportunity to add to this capacity by applying for the Medicare Advanced Primary Care demonstration project, through which Medicare would provide reimbursement through state-led multi-payer medical home initiatives for states selected as demonstration areas.

While the per-person care coordination payments are an important iterative step in payment reform, payment mechanisms must continue to evolve with a focus on improved patient outcomes and experience. Care must be taken to balance payment structures (fees for services, coordination payments and payment for performance) to align financial incentives with quality outcomes and system value.

Plans for 2010. MDH and DHS are working to address these challenges, as well as other issues, as the health care home implementation process continues. Plans for 2010 include:

- Providing technical assistance to clinicians and clinics to build health care home capacity throughout the state.
- Conducting certification workshops throughout the state.
- Announcing first-year outcome measurements and benchmarks and beginning data submission processes.
- Implementing the payment methodology.
- Developing evaluation methodologies for health care homes.
- Continuing to focus on public-private partnerships opportunities through measurement, evaluation and collaborative learning events.

Conclusion

Health care homes offer transformative opportunities to improve the health and patient experience of Minnesota citizens, through changes in primary care delivery, clinic and community infrastructure and culture, and the creation of a patient- and family-centered health care system. With measurement of outcomes focuses on the IHI Triple Aim, payments for services and care coordination, and the establishment of standards and criteria, Minnesota has the right elements in place for true transformation.

Minnesota has been a leader in pursuing policies to improve the health care system, including the use of statutory directives and governmental funding to accelerate the transformational change in primary care delivery. In developing the health care homes certification program, MDH and DHS have provided a model for public-private collaboration to advance health outcomes and care redesign. Improving health, value and the patient experience will continue to be the vision of the health care homes program.

Additional information on health care home implementation in Minnesota can be found at www.health.state.mn.us/healthreform/homes.

Appendix
2008 Health Care Homes Law

[256B.0751] HEALTH CARE HOMES.

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care progs.

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Subd. 4. **Alternative models.** Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Beginning July 1, 2009, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

[256B.0752] HEALTH CARE HOME REPORTING REQUIREMENTS.

Subdivision 1. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors beginning December 15, 2009, and each December 15 thereafter.

Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

(1) the number of state health care program enrollees in health care homes and the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language;

(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees;

(6) the estimated impact of health care homes on health disparities; and

(7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

[256B.0753] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

Subdivision 1. **Development.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to health care homes certified under section 256B.0751 for providing care coordination services and directly managing on-site or employing care coordinators. The care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by

patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be

applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. Development of the payment system must be completed by January 1, 2010.
Subd. 2. **Implementation.** The commissioner of human services shall implement care coordination payments as specified under this section by July 1, 2010, or upon federal approval, whichever is later. For enrollees served under the fee-for-service system, the care coordination payment shall be determined by the commissioner in contracts with certified health care homes. For enrollees served by managed care or county-based purchasing plans, the commissioner's contracts with these plans shall require the payment of care coordination fees to certified health care homes.
Subd. 3. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.

[62U.03] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.
(a) By January 1, 2010, health plan companies shall include health care homes in their provider networks and by July 1, 2010, shall pay a care coordination fee for their members who choose to enroll in health care homes certified by the commissioners of health and human services under section 256B.0751. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0753. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes.
Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.
(b) By July 1, 2010, the commissioner of finance shall implement the care coordination payments for participants in the state employee group insurance program. The commissioner of finance may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.