



Minnesota Department of **Human Services**

Policy Approaches to Support the Medical Home

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NICHQ Forum for Improving Children's Healthcare

Goals

- Trace the development of medical home in MN
- Describe policy approaches in Medicaid and beyond
- Frame the movement from best practice to statewide policy



Minnesota Medical Home Learning Collaborative

- Launched in 2004 and led by the MN Children with Special Health Needs staff at the MN Dept. of Health
- In collaboration with the MN Dept. of Human Services, MN Chapter of the AAP, Family Voices, and a Performance Improvement Advisor
- 25 practice-based teams engaged in collaborative learning and QI, involving ~7,000 children and youth



Development of Primary Care Coordination (PCC)

- State Legislation (2007)
- Leveraging Medicaid funds to make care coordination a state plan service for complex children and adults in fee-for-service public programs
- Goals
- Current Status



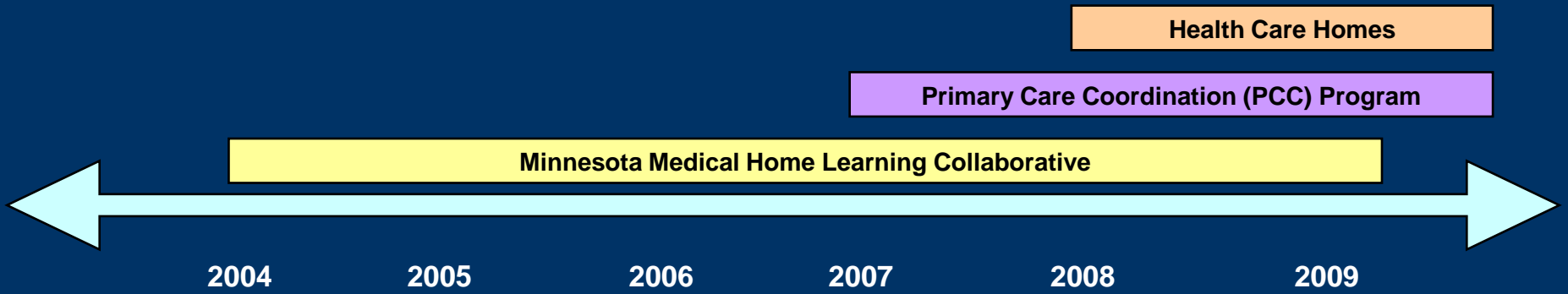
“Health Care Homes”

Legislation → Implementation

- Medical home as a central element of statewide reform (2008 state legislation)
- Development of certification standards and payment methodology – stakeholder involvement
- Patient/family involvement
- Foundational work: capacity assessment (clinics and public), outcomes development



Recent Timeline of Medical Home in Minnesota



PCC: Major Policy Elements

- Provider Criteria
- Patient Selection
- Payment Methodology



PCC: Provider Criteria

- Workgroup Process for Development
- Categories of Provider/Clinic Criteria:
 - Patient-Centered Care Coordination (staff, access, care coordination functions)
 - Care Plan (contents and expected use)
 - Patient Registry
 - Quality Improvement Processes



The Minnesota Model

- Compared to national certification criteria, the PCC (and Health Care Home) standards in Minnesota:
 - Value collaborative quality improvement processes
 - Emphasize patient and family partnerships
 - Have fewer “must have” IT requirements

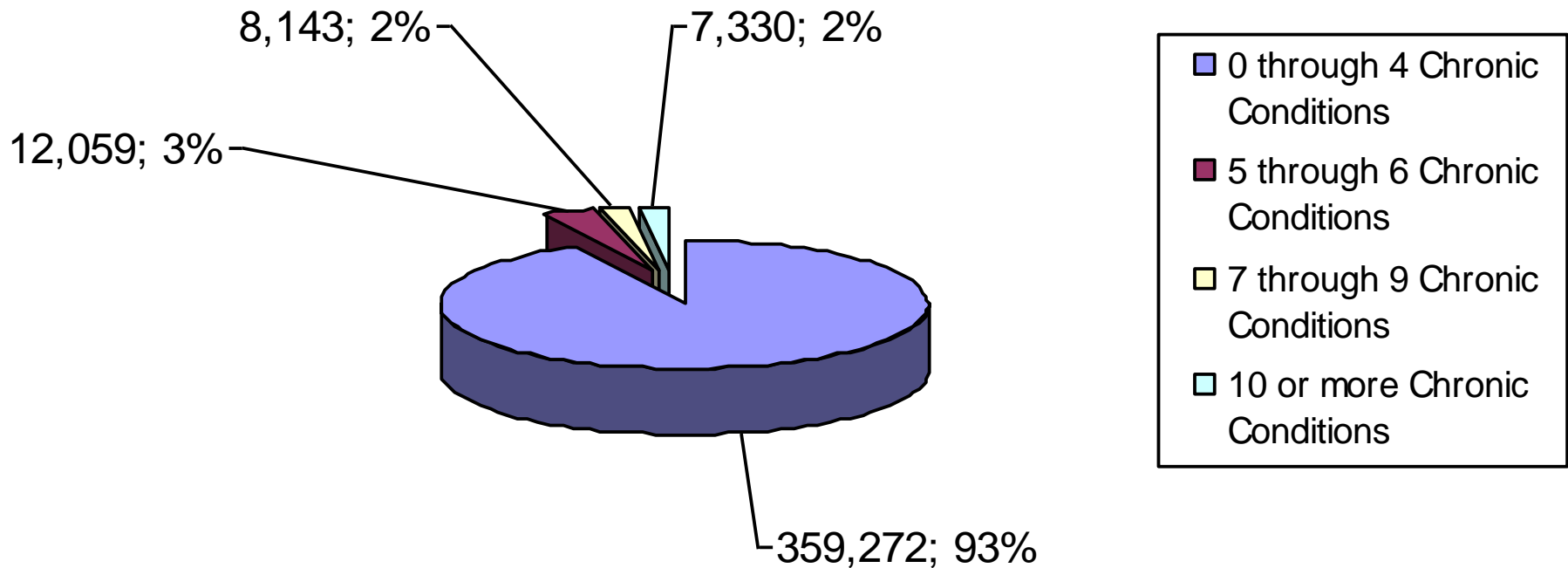


PCC: Patient Selection

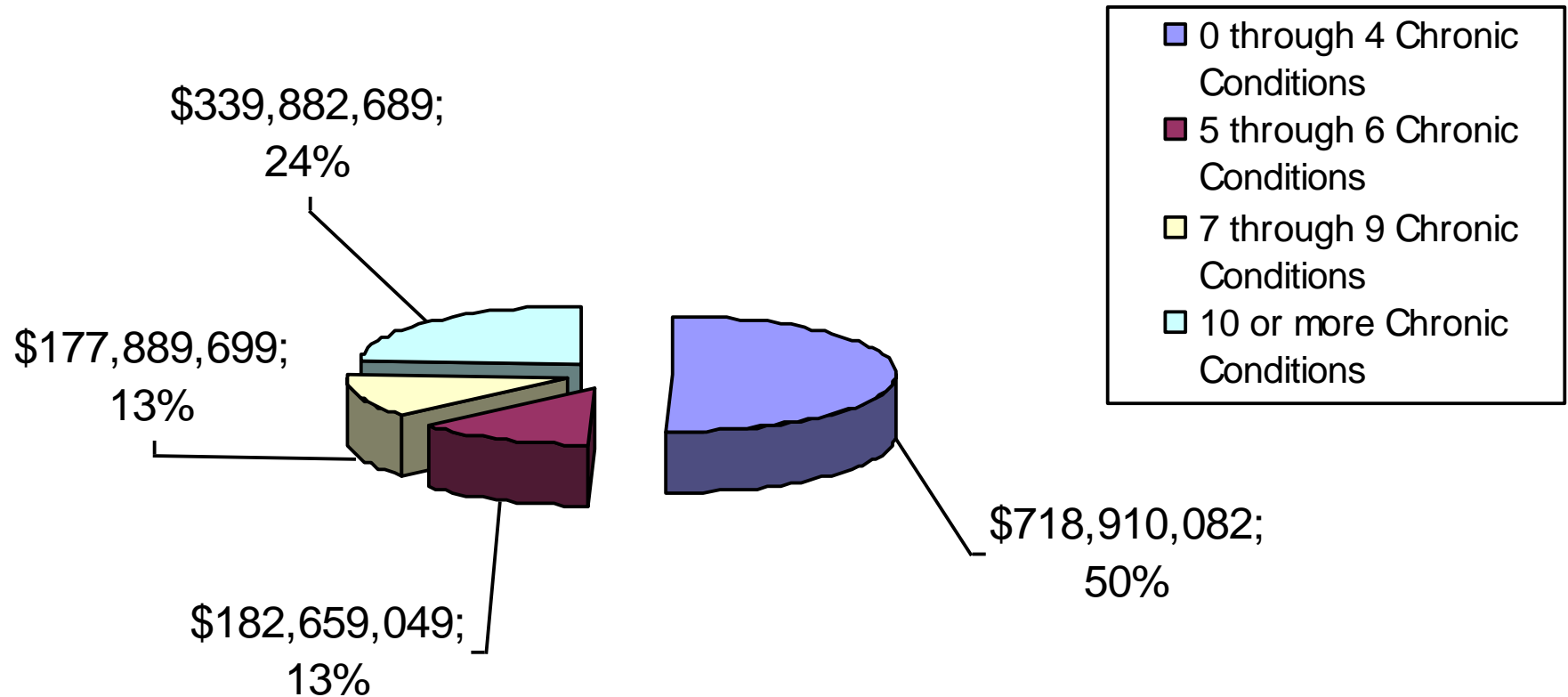
- Importance of Risk Stratification
- ACG Risk Modeling → Provider Checklist of Chronic Diseases
- Process for Enrollment
- Collection of Non Claims-Based Complexity Data



PCC Patient Selection: Count of Eligible Patients



PCC Patient Selection: Health Care Spending for Eligible Patients



PCC: Payment Methodology

- Time studies → expected distribution of staff time
- Assumption of the following distribution with corresponding cost values:
 - 20% Physician or Nurse Practitioner
 - 50% Medical Support Staff
 - 30% Non-Medical Support Staff



PCC: Payment Methodology

- Amounts by Complexity Tier
 - 5-6 Chronic Conditions = \$487 per year
 - 7-9 = \$632 per year
 - 10+ = \$917 per year
- Exponential rather than linear increases in rates reflects spending experience
- Billed in 6-month increments in conjunction with a face-to-face visit: G9002 with modifier for complexity tier



Policy Challenges: PCC

- Pediatric population → Adult population
- Clinic Participation
- Developing objective requirements to pay for care coordination services in a fee-for-service culture – what (else) are we paying for?
- Fostering meaningful, transformative collaborative learning



Broader Policy Challenges: HCH

- Very complex population → (probably) less complex population
- Broad, uniform certification process statewide
- Entry barrier vs. payment for achieving outcomes
- “Codifying a Culture”
- Continued evolution of payment models
- “Critical mass” question (ERISA, Medicare)



Lessons Learned (so far...)

- Value of a legislative champion
- Balancing act of practice expectations, payment, and measuring outcomes
- Building a collaborative process takes time and effort, but it's worth it
- Importance of maintaining shared vision of the definition and goals of medical home
- Primary care reform as health care reform



“Mom, Apple Pie, and Medical Home”

