Minnesota
Advancing the Medical Home Model for Children and Youth
Created in Collaboration with the National Academy for State Health Policy

The National Center for Medical Home Implementation (NCMHI) and the National Academy for State Health Policy (NASHP) are collaborating on the development of state profiles designed to highlight public programs implementing and advancing the medical home model in pediatric populations. These updates are part of a formal partnership between NASHP and the NCMHI that focuses on exchanging information to improve medical home access for children and youth in medically underserved populations. If you have any questions about the information included in the updates, contact medical_home@aap.org.

The NCMHI is a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

Minnesota has a long and successful history of implementing the medical home model to promote comprehensive, coordinated, and patient-centered care for pediatric populations. In 2003, the Minnesota Department of Health (MDH) received a grant from the Health Resources and Services Administration (HRSA) to implement the medical home model for children and youth with special health care needs (CYSHCN) enrolled in Medicaid. Since that time, Minnesota’s medical home efforts have evolved and expanded, culminating in the Health Care Homes (HCH) program, which is transforming primary care for adults and children, including CYSHCN, throughout the state.

Minnesota’s HCH program, established by Minnesota’s 2008 health reform legislation, utilizes the medical home model to redesign the delivery of and payment for primary care statewide. It is designed to facilitate partnerships between providers, patients, and families to improve health outcomes and quality of life for patients, including children and CYSHCN. The HCH program is an approach to primary care for adult and pediatric populations that is patient-centered and coordinated across the health care continuum and facilitates collaboration between primary care providers, specialty providers, and community resources.

PROGRAM COMPONENTS

The HCH program is jointly operated by the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS), which oversees the state’s Medicaid and CHIP programs. Although the HCH program is a multi-payer initiative and includes several other payers (Medicare, state employee insurance, private insurance) in addition to Medicaid, Medicaid is the only payer required to make HCH payments. A statewide Advisory Committee guides the HCH program by developing strategic goals, supporting the delivery of quality care, addressing priorities such as practice transformation and financial sustainability, and exploring opportunities for community partnerships. The Advisory Committee is comprised of researchers, health plan representatives, HCH-certified clinics, state agencies, and health care providers, including pediatric providers.

Primary care clinics can undergo a voluntary certification process to become designated as a HCH and the criteria to become certified are designed to allow for flexibility and innovation for practices. The certification process includes a site visit to the clinic conducted by HCH program staff and an evaluation by community site evaluators to ensure that the criteria have been met. To be certified as a HCH, clinics must meet standards in the following five areas:

- Access and communication
- Patient tracking and registry
- Care coordination
- Care planning
- Performance reporting and quality improvement

Clinics are required to be recertified every three years and recertification is focused on quality outcomes. For 2017, the performance measures on which clinics were evaluated included the following: depression care, diabetes care, vascular care, colorectal cancer screening, and asthma care (for children and adults). Clinics with HCH certification are also required to measure, track, and analyze at least one quality indicator of patient experience and can use different survey tools or questions to assess patient experience. The MDH annually updates the set of quality measures (referred to as the Minnesota Statewide Quality Reporting and Measurement System) that HCHs are required to report on.
PAYMENT MODEL

The DHS and MDH developed a tiered payment model for the HCH program that applies to all participating adult and pediatric providers. The tiered payments are based on each patient’s medical complexity level and their care coordination needs. Providers assess each patient to determine the number of “major conditions groups” (e.g., cardiovascular, respiratory, and endocrine) that are severe, chronic, and require a care team to manage. Then the HCH practices submit claims based on the patient’s medical complexity tier (see tier structure below).

Medical Complexity Tier Structure

- Tier Zero: No Major Condition Groups
- Tier 1 (1-3 Major Condition Groups): $10.14
- Tier 2 (4-6 Major Condition Groups): $20.27
- Tier 3 (7-9 Major Condition Groups): $40.54
- Tier 4 (10+ Major Condition Groups): $60.81

Additionally, clinics receive a 15 percent increase in the payment for each patient that either has a serious mental illness or who does not speak English as their primary language. If the patient meets both factors, the payment is increased by 30 percent. Only clinics that have been certified as HCHs by MDH are eligible to receive the tiered care coordination payments based on medical complexity.

The HCH program also lays the foundation for participating clinics and practices to participate in broader statewide health reform efforts that are designed to move Minnesota from fee-for-service (FFS) payment systems to value-based payment (VBP) systems, such as accountable care originations and bundled payments that reward providers for value and performance. The HCH program is building provider capacity for practice transformation, care coordination, and quality measurement and reporting, all of which are critical elements of successful alternative payment models. In fact, as of 2016, 163 HCHs were participating in Integrated Health Partnerships (IHP). The IHP is Minnesota Medicaid’s accountable care organization program that holds providers accountable for the costs and quality of care for their population of attributed Medicaid patients.

CROSS-SYSTEM PARTNERSHIPS

Minnesota’s medical home efforts have been the product of strong cross-agency and cross-system partnerships. For example, DHS and MDH partnered in the implementation of Minnesota’s State Innovation Model (SIM) testing grant, which the state received from the Center for Medicare and Medicaid Innovation to test new ways of payment and service delivery approaches using the Minnesota Accountable Health model framework. The Minnesota Accountable Health Model sought to expand patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services. One of the strategies of this framework was the Accountable Communities for Health program, which was designed to improve population health by integrating and coordinating care from the clinic level (e.g., HCH) to communities. Between 2013 and 2017, SIM grant dollars also supported and expanded the reach of HCHs by providing grants to support structural improvements and transformation activities among the participating adult and pediatric practices. The MDH also created learning communities to provide forums for HCH providers and other stakeholders to learn from each other, and gain insights on topic areas that would advance their transformation efforts such as the integration of the HCH model for pediatric populations and enhancing care coordination for CYSHCN. While Minnesota’s SIM grant program ended in December 2017, the state plans to continue to support practice facilitation and transformation efforts through the HCH program.

Additionally, the state MCH Title V / CYSHCN program staff have participated in HCH program work groups to ensure that the needs of CYSHCN are considered in the HCH program design and certification standards. Minnesota’s HCH program also leveraged its partnerships with primary care provider associations, including the Minnesota Chapter of the American Academy of Pediatrics, the Minnesota Academy of Family Physicians and the American College of Physicians-Minnesota Chapter, to help build clinics’ capacity to become HCHs and maintain their certification. They have provided education and training sessions via webinars and workshops and have also provided direct technical assistance to providers and clinics.
OUTCOMES

As of March 2018, 389 clinics have been certified as HCHs in Minnesota and only 23 (of 87) counties do not have HCH-certified clinics. In 2014, 507 pediatric providers, representing nearly half of all pediatric providers in the state, were providing care in clinics with HCH certification. An estimated 71 percent of children and adolescents in Minnesota were being served by HCH-certified clinics in 2016.

An evaluation study of the HCH program found that HCH-certified clinics were associated with higher quality of care for vascular disease, diabetes, depression, asthma in children and adults, and colorectal cancer screening than non-HCH clinics. Asthma care for children in HCHs saw the largest difference in quality of care, with HCHs receiving 20 percentage point higher rating than non-HCH clinics. The HCHs also were associated with lower utilization of hospital inpatient and outpatient services, and they were found to provide care at lower costs than non-HCHs, resulting in over $1 billion in savings for the state between 2010-2014. These data demonstrate the transformative efforts of the HCH program statewide.

FAST FACTS:

521,823: The number of children enrolled in Medicaid and CHIP in Minnesota as of November 2017

94.2%: The participation rate for those eligible for the Minnesota Medicaid/CHIP program in 2015

93.1%: The national participation rate for those eligible for the Medicaid/CHIP program in 2015