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Marie Maes-Voreis, RN PHN, MA
Director Health Care Homes

Minnesota Health Reform

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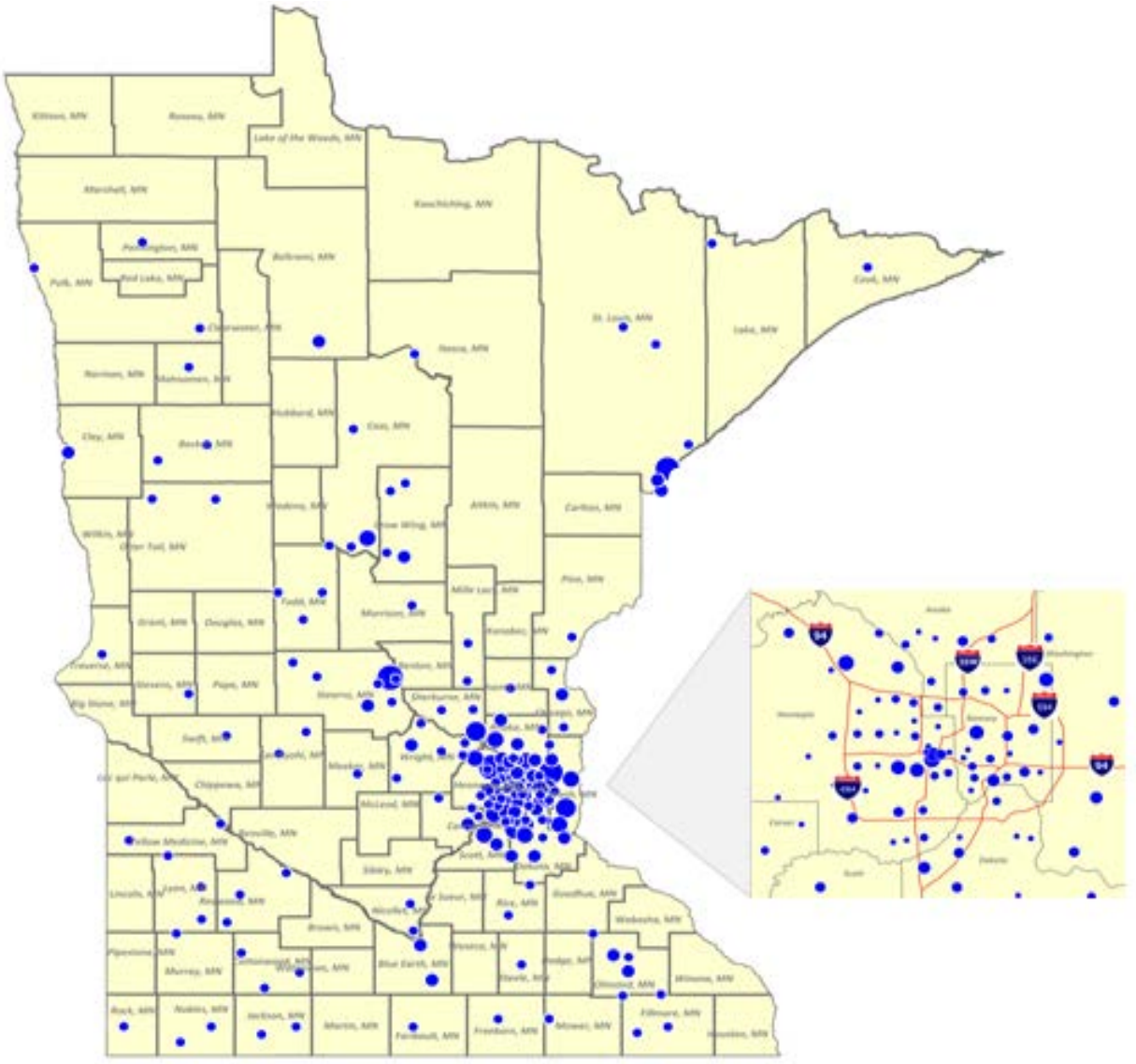
Minnesota Health Care Homes

322 certified HCHs, 42% of primary care clinics

3,429 certified clinicians

Serving 3.3 million Minnesotans



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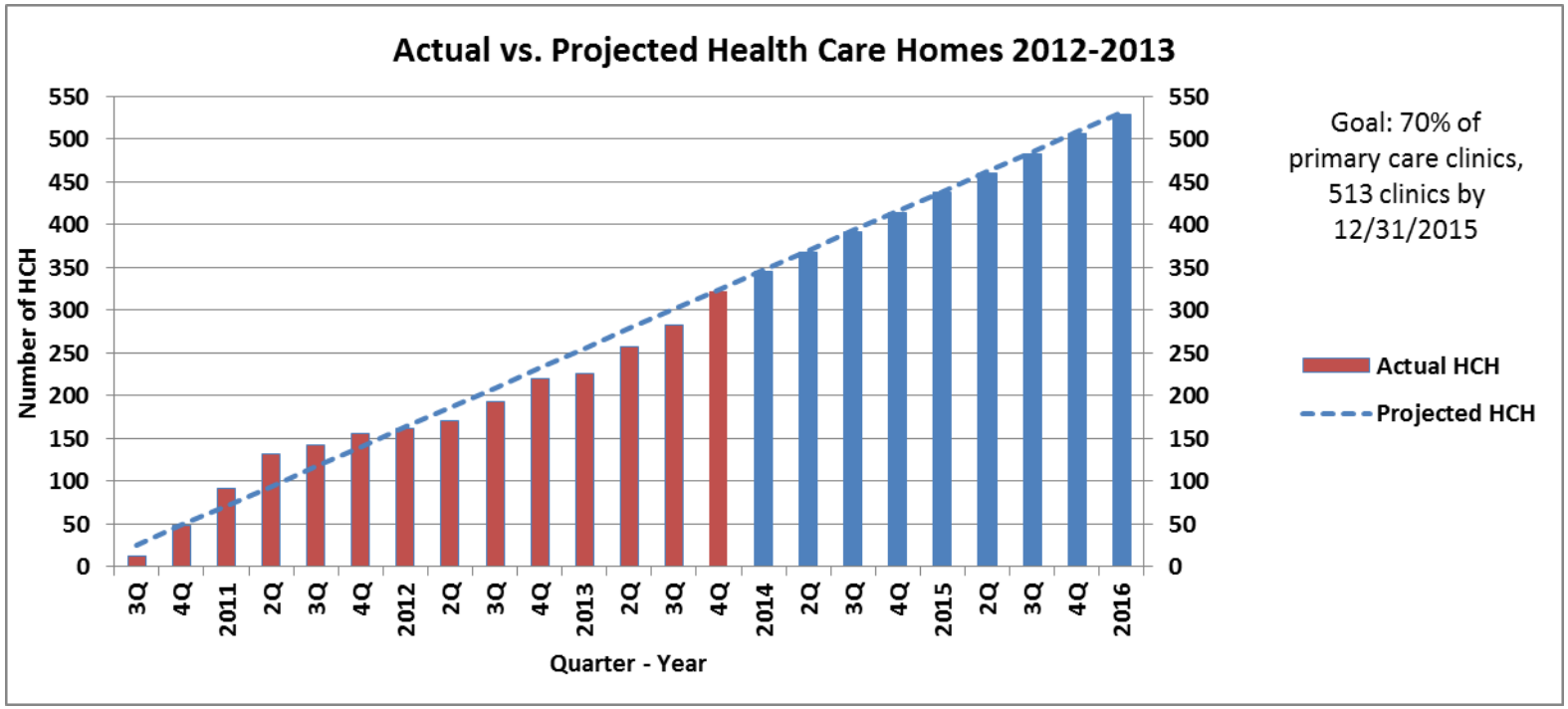
Health Care Home Certification Progress



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What Is Working for Minnesota?

- **Statewide approach, public/private partnership**
- Standards for certification all types of clinics can achieve
- Support from a statewide learning collaborative
- Development of a payment methodology
- Integration of community partnerships to the HCH
- Outcomes measurement with accountability
- Statewide HCH Evaluation supported by legislation.

Focus on patient- and family-centered care concepts

Health Care Homes Contact Information

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Evaluation of the State of Minnesota's Health Care Home Initiative

Evaluation Report for 2010-2012

University of Minnesota School of Public Health

Division of Health Policy and Management

Douglas Wholey, PhD., Michael Finch PhD, Katie M. White PhD, Jon Christianson PhD, Rob Kreiger PhD, Jessica Zeglin MPH, Suhna Lee MPA, Lindsay Grude BS.

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HCH Evaluation

- Minnesota Statute §256B.0752 directs the commissioners to complete a comprehensive evaluation report of the HCH model three and five years after implementation (2013 and 2015).
- This 2013 report describes the implementation and outcomes of the HCH initiative from July 2010 – December 2012 for Medicaid enrollees in certified HCH clinics compared to those in non-HCH clinics.

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Evaluation Team

Evaluators

- University of Minnesota
  - Douglas R. Wholey, MBA, PhD (PI), Michael Finch, PhD (Co-PI), Katie White, MBA, PhD, Rob Kreiger, PhD, Jon Christianson, PhD, Jessica Zeglin, MPH, Lindsay Grude, BS, Suhna Lee, MPA

Collaborators

- Minnesota Department of Health (funder)
  - Marie Maes-Voreis, RN, MA, Director, Health Care Homes, Monica Hemming, Analyst, Health Care Homes
- Minnesota Department of Human Services
  - Marie Zimmerman, Sarah Bonneville, MS, Heather Petermann, MS

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HCH Initiative Background

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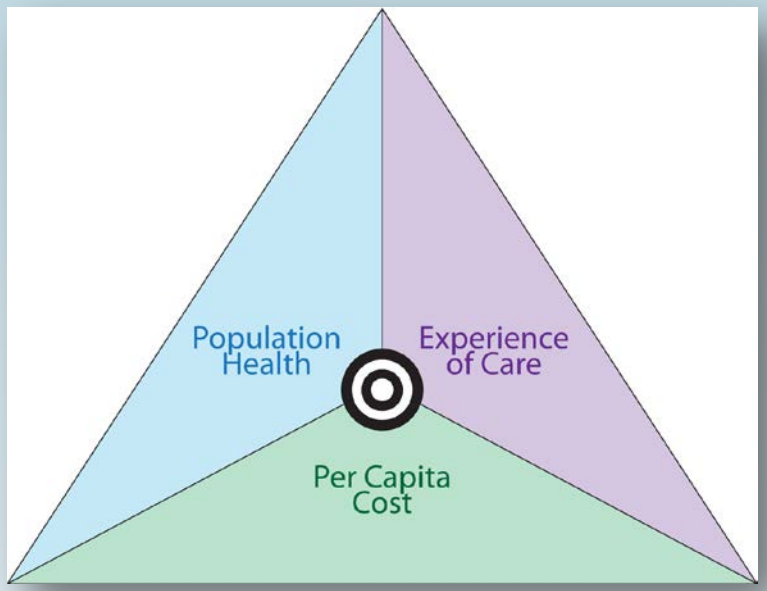
Health Reform in Minnesota

Minnesota's Three Reform Goals

- Healthier communities
- Better health care
- Lower costs



Institute of Medicine's Triple Aim

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MN Evaluation Preparation

- Health Reform laid a strong foundation for the HCH evaluation
  - State Quality Measurement and Reporting System
    - Assures statewide reporting of primary care clinics on quality and outcomes measures
    - Data collected from clinics by Minnesota Community Measurement
    - Quality data on diabetes and vascular care available from 2009
  - eHealth, ePrescribing, EHR Interoperability standards
  - Development of HCH certification standards and certification process built on strong stakeholder involvement
    - Assures that all HCH certified clinics meet the basic HCH medical home model

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Health Care Home

Health Care Home is not:

- A nursing home or home health care
- A restrictive network
- A service that only benefits people living with chronic or complex conditions

Health Care Home is:

- Population clinical care redesign
- Transformed services to meet a new set of patient-and family-centered standards to achieve triple aim
- Foundation to new payment models such as ACOs
- Community partnerships that build healthy communities

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Consumer Perspective: Better Health Made Easy

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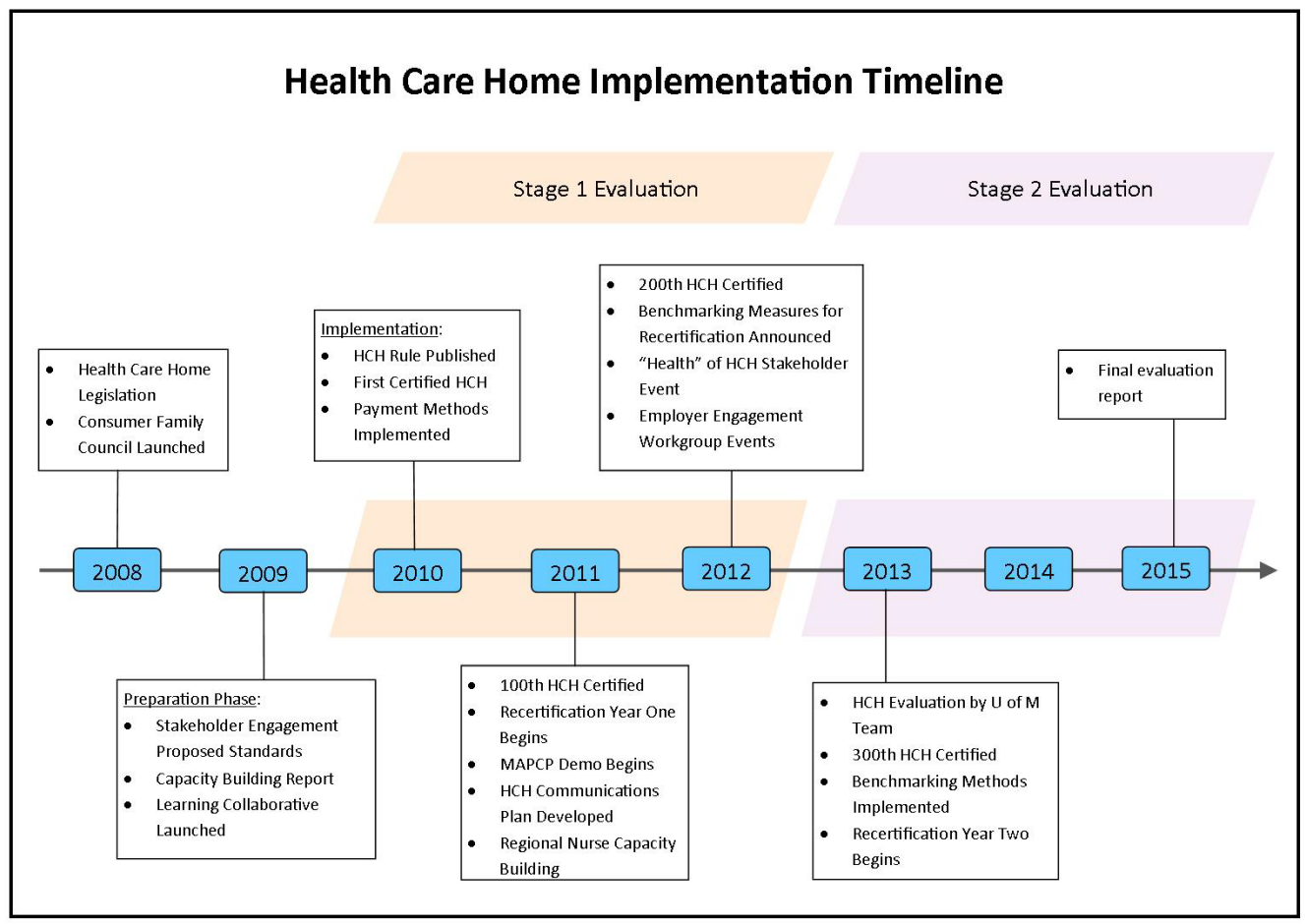
HCH Implementation Timeline



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Phase 1 Evaluation

- Responds to specific Minnesota legislative request for evaluation of demographics, quality, use of payment, disparities, and estimated costs
- Shows comparisons between HCH clinics and non-HCH comparison clinics on measures of access, quality, and cost
  - Focuses on a 'real world' evaluation of an initiative that is open to all HCH-eligible clinics, primary care clinics
  - Focuses on actual quality experience and dollars spent by Medicaid program for the HCH and non-HCH population from 2010-2012
- What future evaluation phase will add
  - Examine the impact and causal effects of the HCH Initiative on access, quality, and cost
  - Risk adjust cost and quality measures
  - Take into account the changing mix of clinics becoming certified and enrollees served by HCHs

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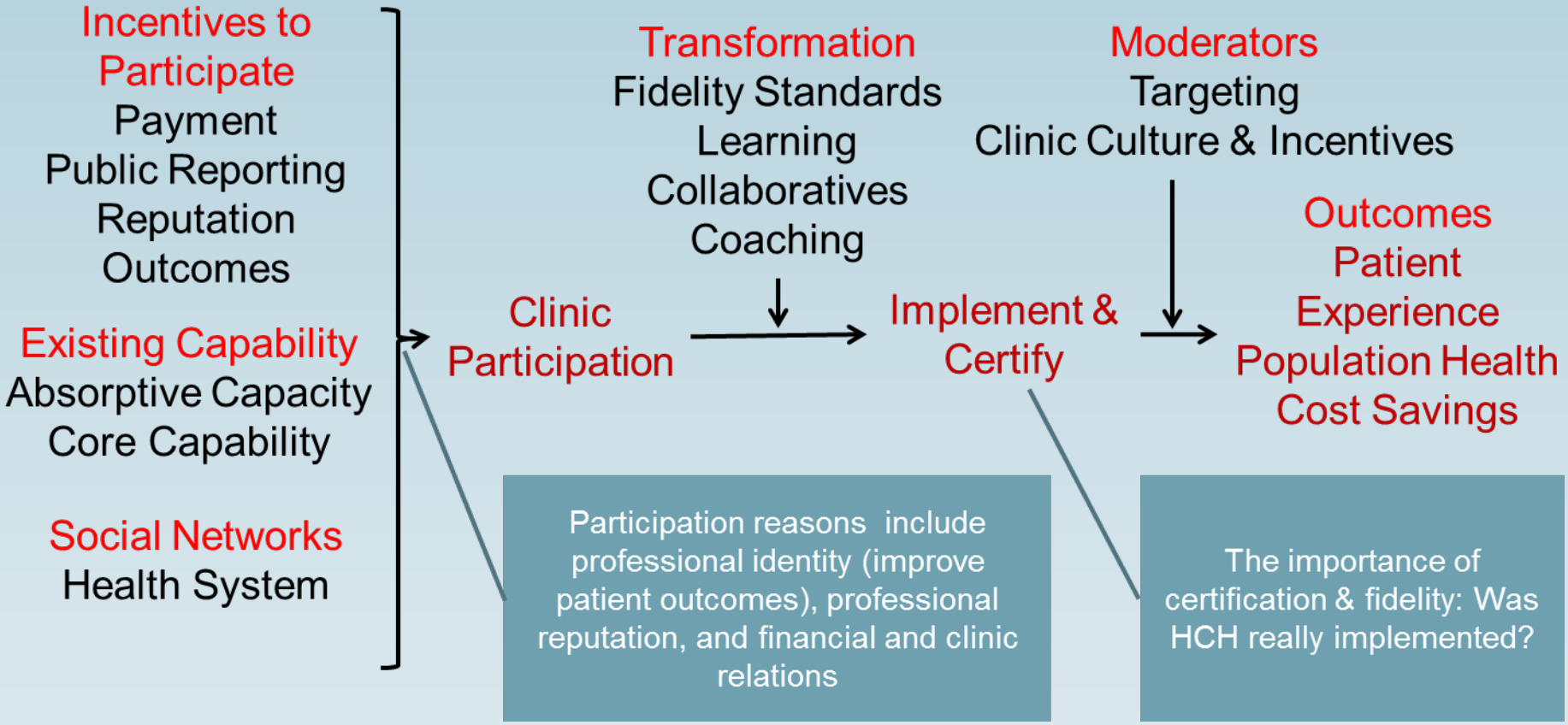
The HCH Initiative: A Stylized Logic Model



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2013 HCH Evaluation Report Overview

- The 2013 HCH Evaluation includes:
  - Key Findings
    - HCH Model
    - Provider & Enrollee Demographics
    - Care Quality
    - Payment
    - Disparities in Care
    - Estimated Costs & Cost Savings
  - Limitations
  - Next Steps

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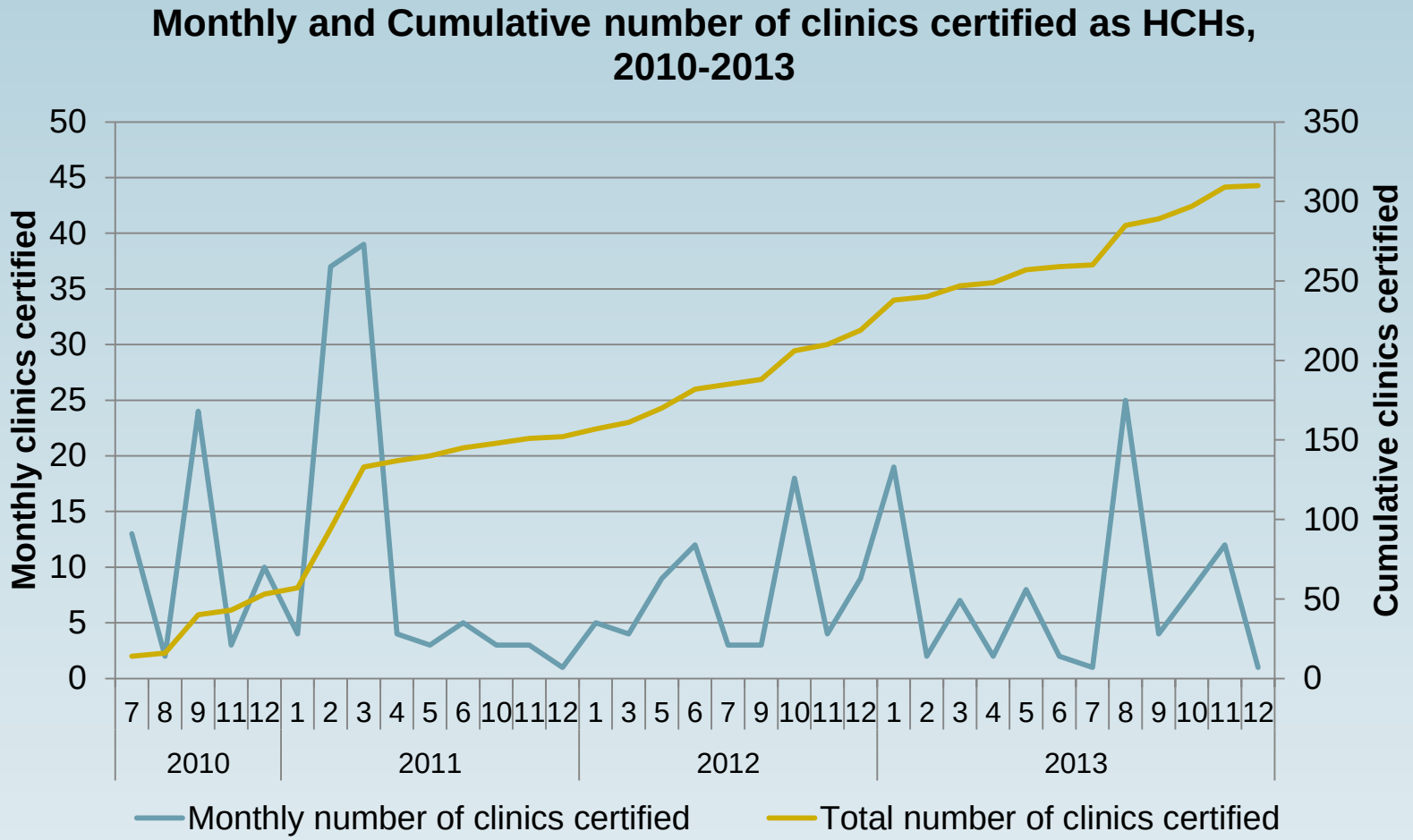
Evaluation Findings

HCH Model: Fidelity and Certification

- HCH model includes a rigorous certification process, including direct observation during site visits to assess HCH implementation
  - Follows recommended evaluation standards
  - Assures evaluation reliability

Key Findings: Provider Demographics



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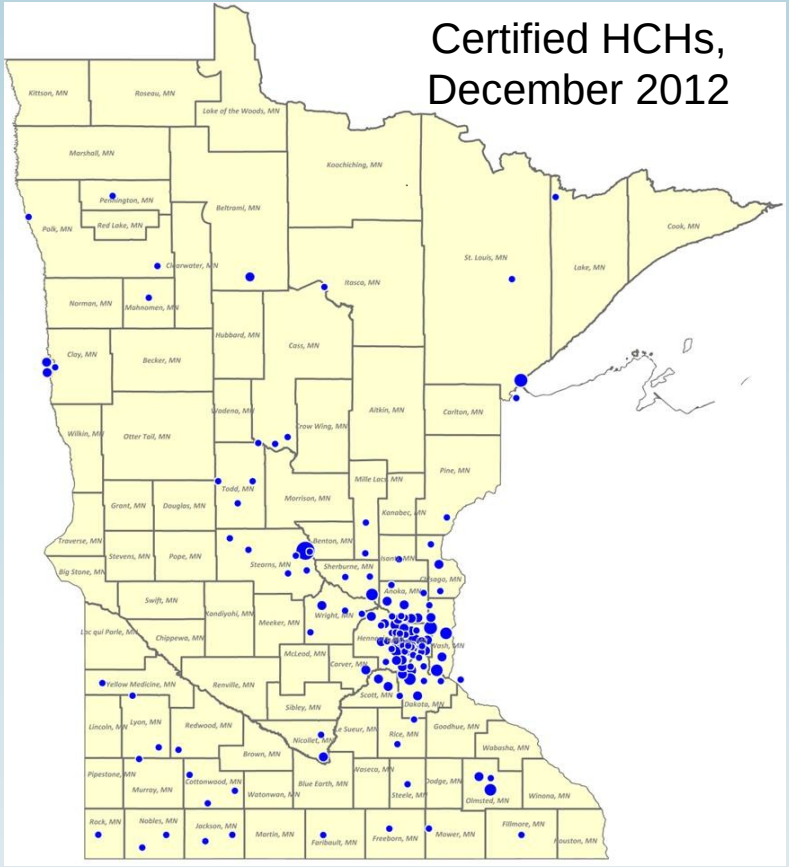
Key Findings: Provider Demographics (2)



- Just over 53% of HCHs are in the Minneapolis-St. Paul metropolitan area, but HCHs are represented in many areas of Minnesota
- Larger clinics, clinics with higher care quality, and clinics serving more MHCP patients are more likely to become certified

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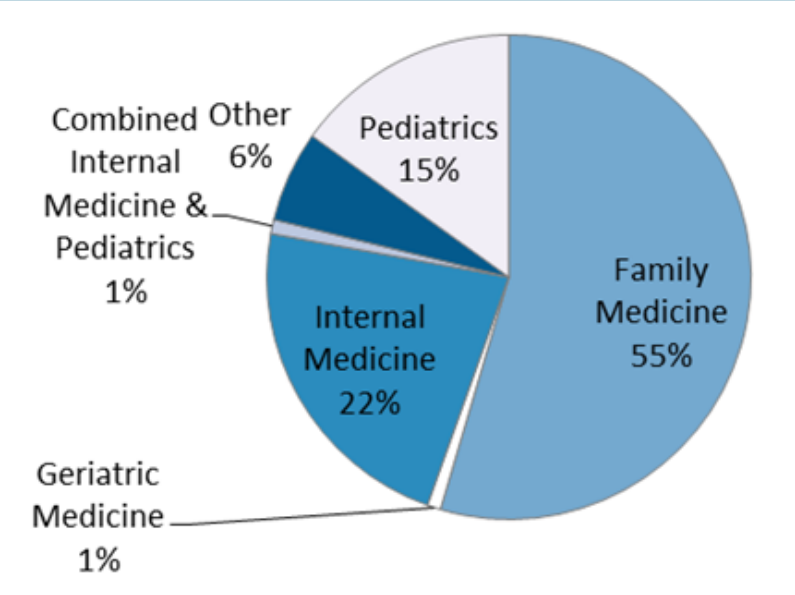
Key Findings: Provider Demographics (3)

HCH providers by specialty, March 2011



- Nearly half of Family Medicine and Pediatrics providers in the state provide care within HCHs.
- Certified HCH providers are largely Family Medicine providers, with Internal Medicine and Pediatric specialties also represented.

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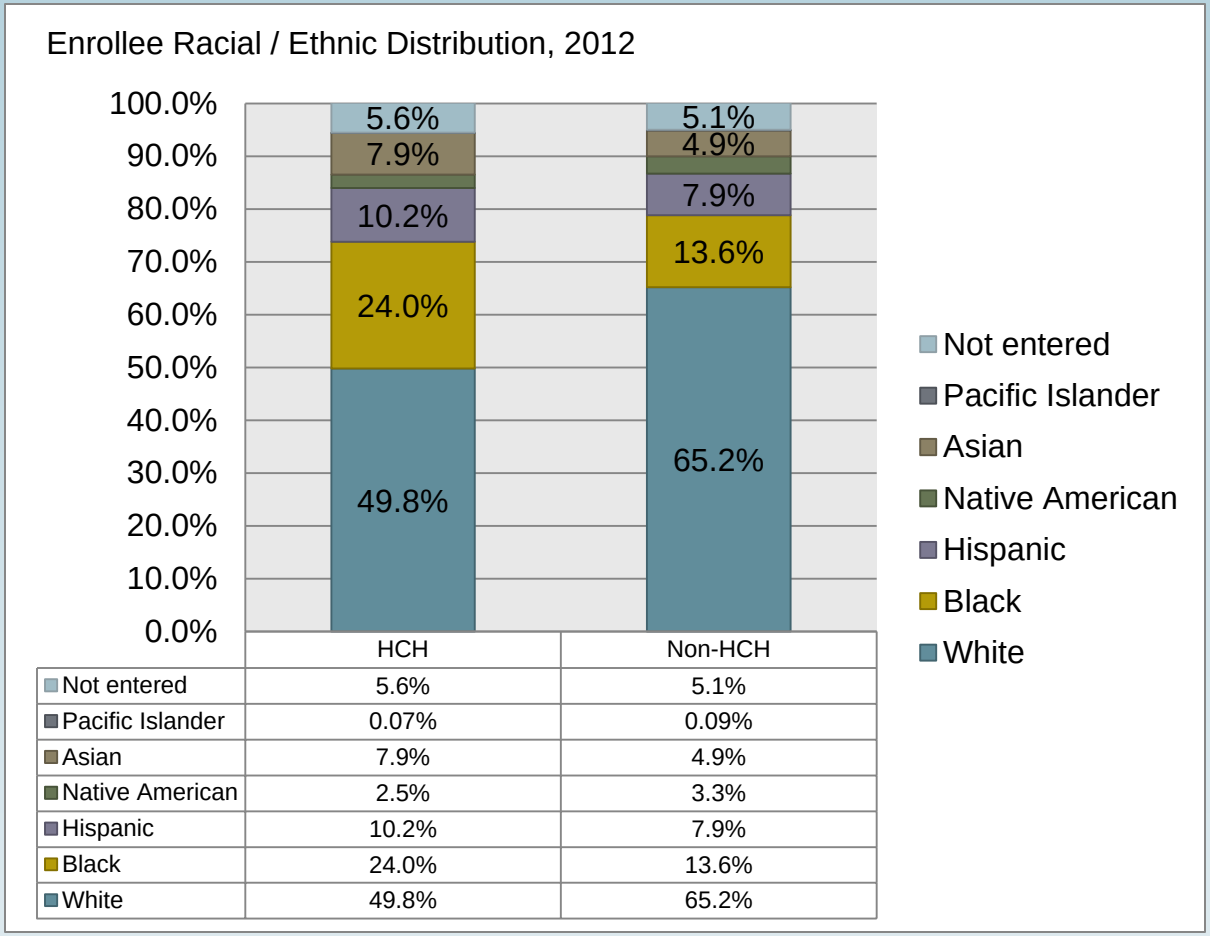
Key Findings: Enrollee Demographics

- Number and percent of Medicaid enrollees in certified HCH clinics increases over time
- HCH clinics tend to care for patients who:
  - Are in higher HCH payment tiers, have higher expenses
  - Are persons of color, speak a primary language other than English, have lower levels of educational attainment
- HCHs appear to be serving populations targeted by the initiative, including enrollees from historically disadvantaged populations

Key Findings: Enrollee Demographics (2)

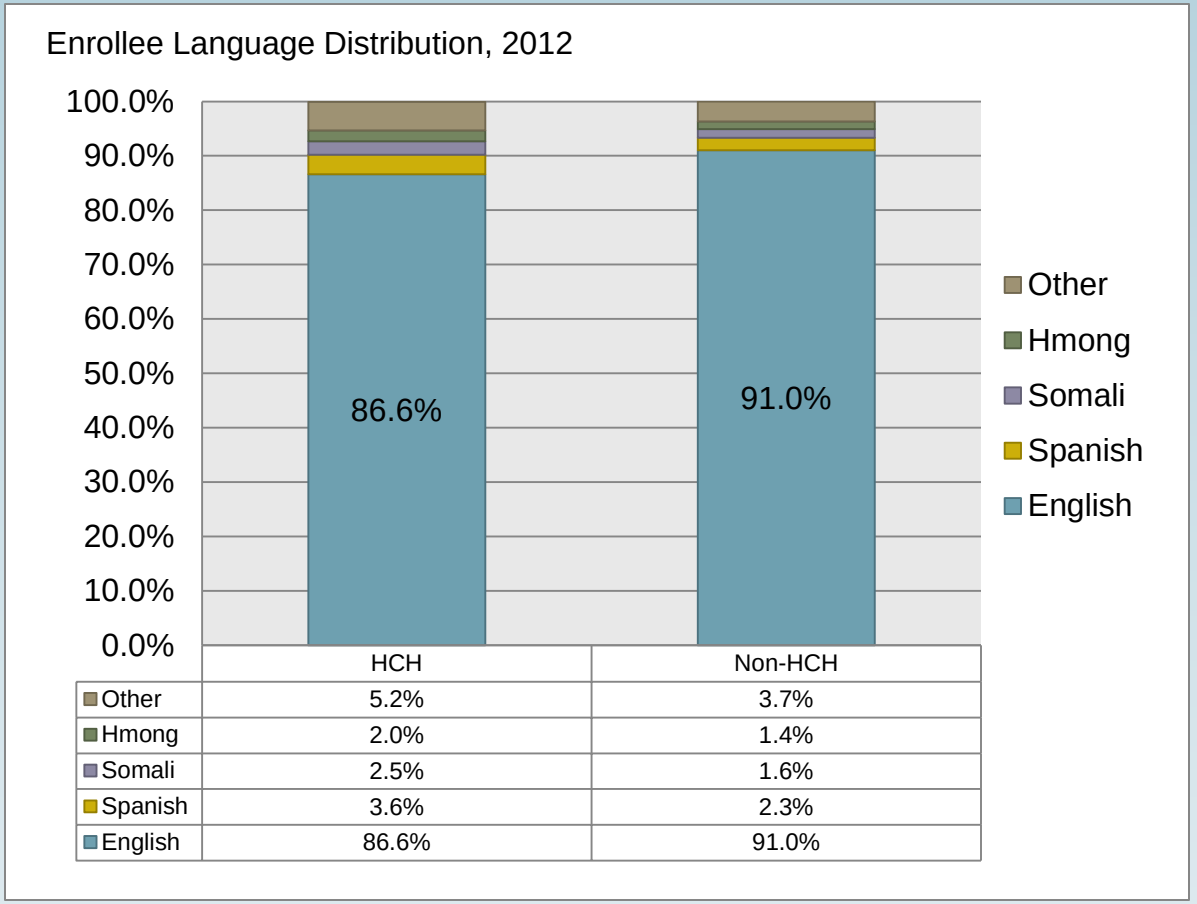
- HCHs tend to care for greater proportions of patients from racial and ethnic minority populations



	HCH	Non-HCH
Not entered	5.6%	5.1%
Pacific Islander	0.07%	0.09%
Asian	7.9%	4.9%
Native American	2.5%	3.3%
Hispanic	10.2%	7.9%
Black	24.0%	13.6%
White	49.8%	65.2%

Key Findings: Enrollee Demographics (3)

- HCHs tend to care for greater proportions of patients who speak a primary language other than English



	HCH	Non-HCH
Other	5.2%	3.7%
Hmong	2.0%	1.4%
Somali	2.5%	1.6%
Spanish	3.6%	2.3%
English	86.6%	91.0%

Assessing Care Quality: Methods

- Assessments of quality of care were based on the Statewide Quality Reporting and Measurement System (SQRMS) quality data collected by Minnesota Community Measurement (MNCM).
- SQRMS requires all physician clinics in Minnesota to submit data on quality measures.
- SQRMS measures include commercial, Medicare, MHCP, uninsured, self-pay patients

- Quality measures included:
  - Optimal and Average Diabetes Care
  - Optimal and Average Vascular Care
  - Depression Remission at 6 months
  - Optimal and Average Asthma Care
  - Colorectal Cancer Screening

Details of SQRMS at: http://www.health.state.mn.us/healthreform/measurement/adoptedrule/

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Assessing Care Quality: Methods (2)

- SQRMS Data Collection
  - Primary care clinics collect and submit patient data on quality
  - Clinics may submit data on total clinic patient population or a representative sample of the population
  - Data are collected and validated by MNCM
- SQRMS Quality Population
  - ~750 HCH eligible clinics included in quality analysis
    - 221 HCH certified clinics
    - Number of clinics included vary by quality measure

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Assessing Care Quality: Methods (3)

- Assessed 2 types of measures
- Optimal Care Measures
  - Measure is considered ‘met’ when a patient achieves all component measures
  - For example: Diabetes Optimal Care is met when a patient achieves all targets:
    - HbA1c level (<8.0)
    - LDL level (<100 mg/dL)
    - Blood pressure (<140/90 mmHg)
    - No tobacco use
    - Aspirin use (if patient has comorbidity of ischemic vascular disease)
- Average Care Measures
  - Determines the percentage of total component measures met
  - Example: Diabetes Average Care is 80% when a patient:
    - Achieves HbA1c level, LDL level, blood pressure level, and aspirin use targets (4/5 achieved)
    - Uses tobacco (1/5 not achieved)

HCHs Had Better Care Quality

		HCH vs. Non-HCH	
		HCH higher quality	No difference
Colorectal Cancer Screening		✓	
Depression	Remission at 6 months		✓
	Follow-up at 6 months	✓	
Asthma Care	Optimal	✓	
	Average	✓	
Diabetes Care	Optimal	✓	
	Average	✓	
Vascular Care	Optimal	✓	
	Average	✓	

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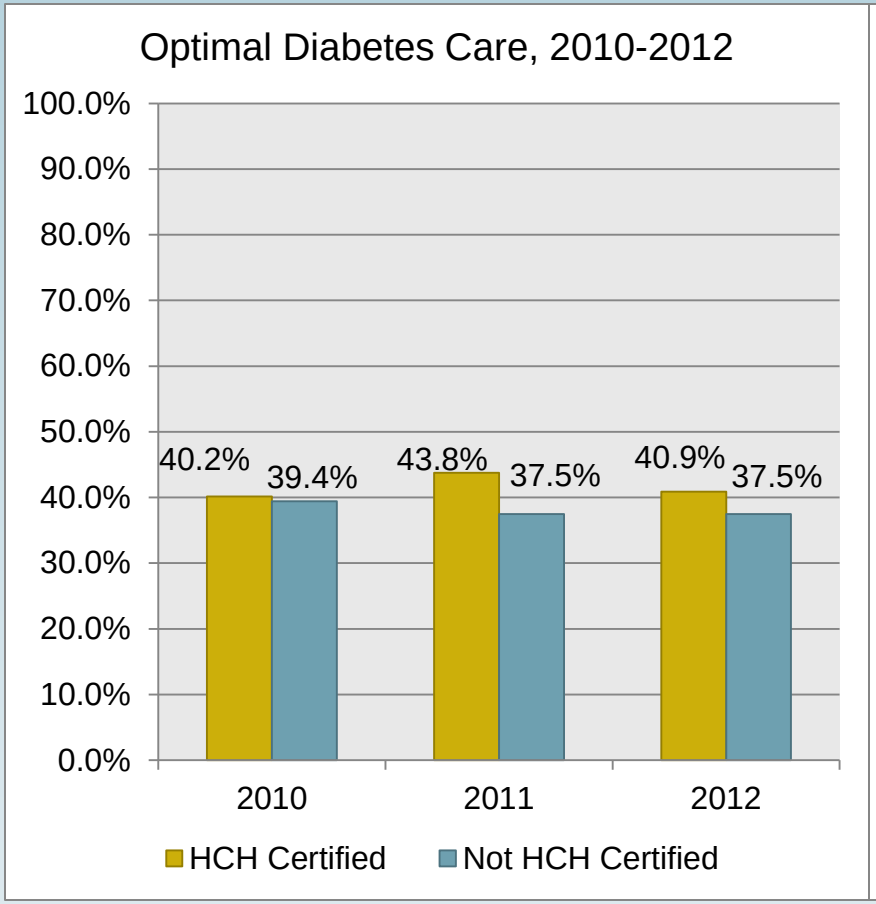
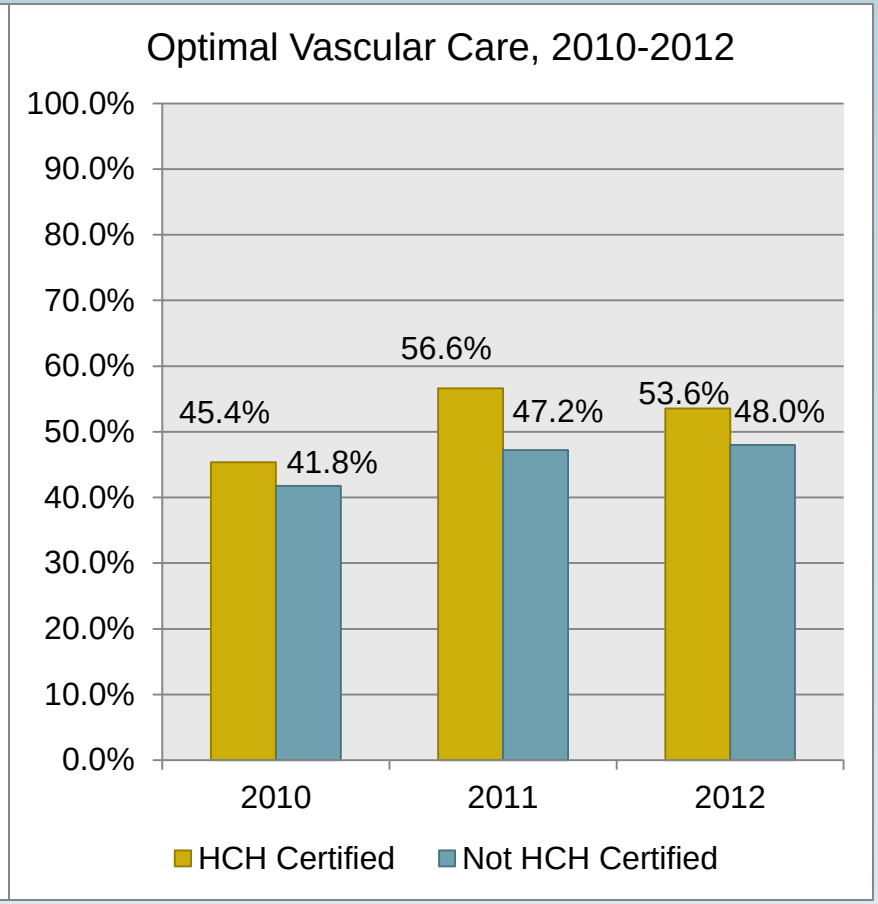
Key Findings: Care Quality





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Assessing HCH Payment Experience: Methods

- Administered 3 surveys to all HCH clinics and clinic organizations certified as of December 31, 2012
  - Billing Practices Survey
    - Asked HCHs about decisions and preparations made for clinic billing for monthly care coordination services
  - Financial Practices Survey
    - Asked HCHs about financial analyses conducted prior to becoming certified, financial monitoring processes, and the importance of care coordination payments
  - Patient Tiering Practices Survey
    - Asked HCHs about the tools and processes used to complete the tiering process, how tiering connects with the billing process, and the effectiveness of tiering

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Assessing HCH Payment Experience: Methods (2)

Survey response rates

Survey	# of organizations responding	% of total organizations	# of clinics represented	% of total clinics represented
Finance	30	85.7%	211	97.2%
Billing	27	77.1%	199	91.7%
Tiering	26	74.3%	198	91.2%
Total sample	35	100%	217	100%

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Key Findings: Payment

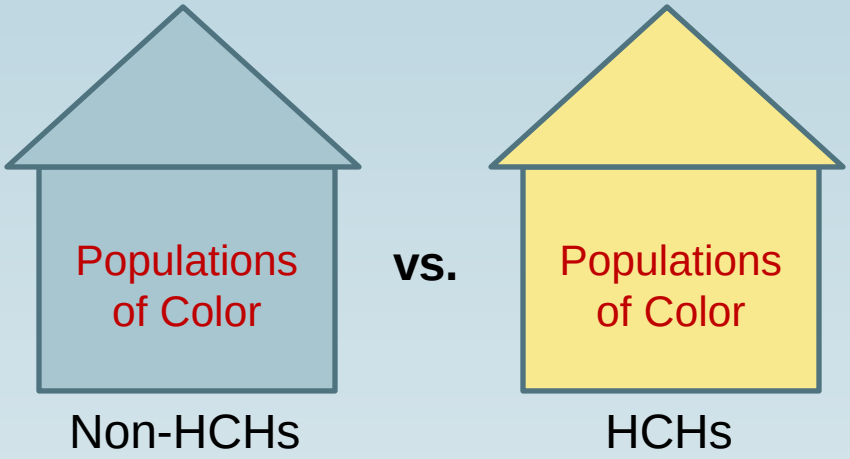
- Surveys of Health Care Home organizations certified between 2010-2012 indicated that:
  - Financing HCH services, including collecting payment for care coordination services, is important to HCH organizations
  - Financial incentives do not appear to be a primary driver of HCH participation
  - HCH organizations were better able to capture payment due to them for care coordination services from Medicaid than from Medicare, managed care, and commercial insurers
  - Some HCHs report experiencing cost increases associated with operating as a HCH, which appear to be related to start-up expenses of program implementation
  - Most HCH clinics are using the MN Care Coordination Tier Assignment tool for billing
    - Tool is adequate for current use
    - Some modifications may improve usefulness

Key Findings: Disparities in Care

- Analyses suggest HCHs are serving target populations:
  - Enrollees w/ higher severity medical conditions
  - Disadvantaged populations

Key Findings: Disparities in Care (2)

- Compared to populations of color in non-certified clinics, populations of color in HCH clinics:
  - Used fewer emergency department and ambulatory surgery services
  - Had fewer E&M visits
  - Used more professional services and significantly more hospital outpatient services



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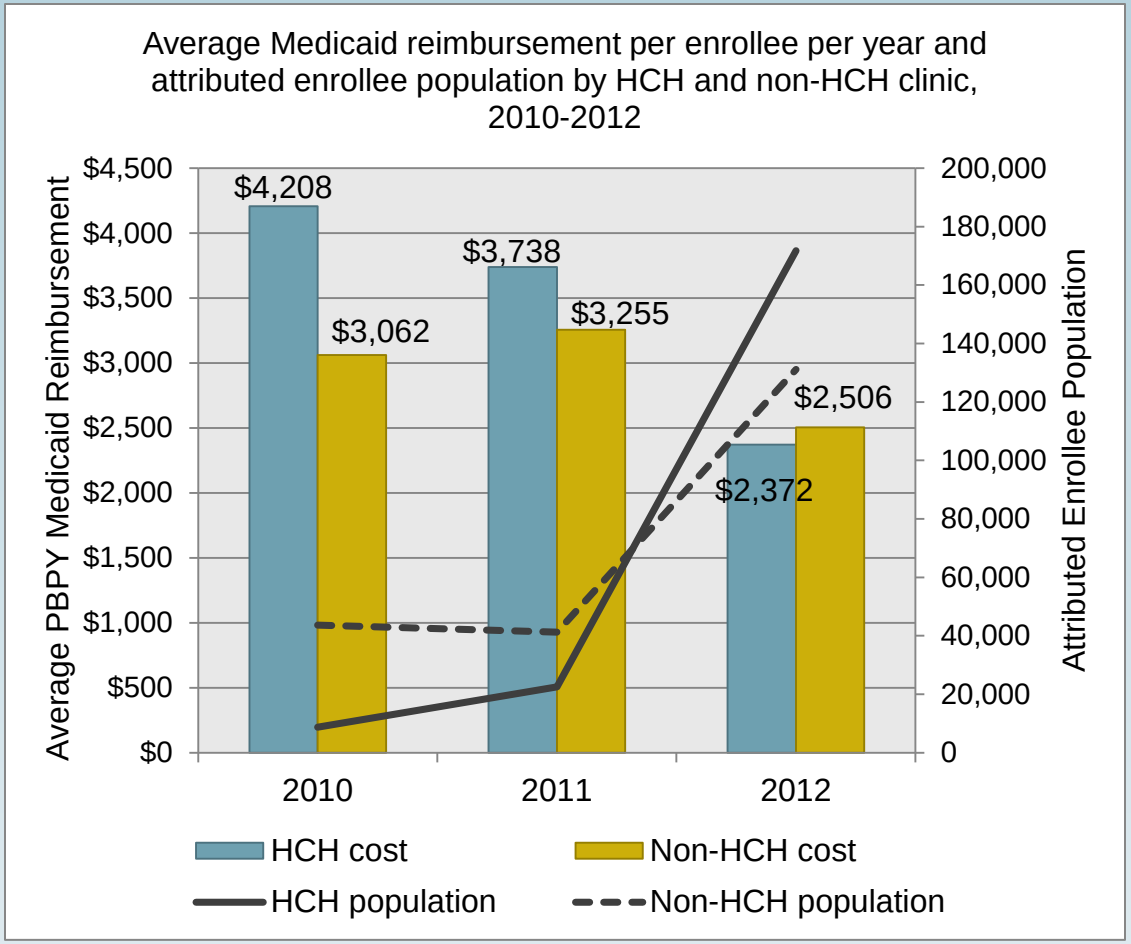
Key Findings: Estimated Costs & Cost Savings

- HCH Medicaid enrollees were more expensive during start-up year but became less expensive than non-HCH enrollees by 2012



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Key Findings: Estimated Costs & Cost Savings (2)

- Overall, HCH enrollees had 9.2% less Medicaid expenditures than non-HCH enrollees

Calculation of Medicaid Cost Savings over 3 years of Health Care Homes Initiative				
	Total Number of Attributed Enrollees over 2010, 2011, and 2012	Total Cost for attributed enrollees over 2010, 2011, and 2012	Average Cost per Attributed Enrollee over 2010, 2011, and 2012	Estimated HCH Cost Savings over 2010, 2011, and 2012
HCH clinics	203,071	$525,626,946	$2,588	9.2%
Non-HCH clinics	264,523	$753,975,197	$2,850	

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Summary

- Health Care Homes are associated with greater access to care, greater quality of care, and lower health care costs over the evaluation period (2010-2012) as compared to similar primary care clinics not certified as Health Care Homes.

Limitations of Initial Evaluation

- HCH initiative is in beginning phase
  - While clinic and enrollee participation is increasing over time, the participation rates in initial phases made initial evaluation difficult
  - HCH effects may take a while to emerge because transformation to the HCH model may take time for refinement
- Measurement of costs and resource use
  - Resource use analysis depends on attributing enrollees to clinics
  - Attribution is improving over time because of improved data associating providers with clinics and patients with providers

Next Steps

- Interim evaluation to MDH in 2014, final evaluation to MN State Legislature in 2015
- Next steps to continue and deepen evaluation:
  - Including more data as it becomes available (e.g. Medicare)
  - Estimating effect of HCH initiative on clinic transformation (and therefore changes in access, cost, and quality)
  - Estimating effect of HCH initiative on patient experience
  - Examining how HCH effects differ across enrollee populations (such as by socio-economic status, race/ethnicity, urban/rural)
  - Improving evaluation methods, such as attribution, risk adjustment, and causal modelling
  - Determining causal relationship between HCH Initiative and impacts on access, quality, disparities, and cost

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Recent JAMA article on Medical Homes

- Friedberg, M. W., et al. (2014). "Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care." JAMA 311(8): 815-825.
  - Population Studied: 32 intervention clinics compared to 29 matched clinics over 3-year period from 2008-2011
  - Model: Pilot practices received disease registries and technical assistance to facilitate transformation to National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition
  - Outcomes: Limited improvements in quality (1 of 11 assessed measures was higher for PCMH) and no reductions in health care utilizations or total costs over 3 years

- Phase 1 MN HCH Evaluation
  - Population Studied: 224 HCH certified clinics compared to approximately 500 similar HCH eligible clinics over 3-year period from 2010-2012
  - Model: Transformation to MN Health Care Home including site visits to ensure that participating practices meet a suite of HCH standards including population health management focus, team based care, electronic searchable registries, care plans, continuous access to all enrollees, coordinated care processes, and patient engagement.
  - Outcomes: HCHs associated with improved access for disadvantaged populations, higher quality than non-HCHs in 8 of 9 quality measures, lower cost than non-HCHs of 9.2% less in total health care costs over 3 years

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Comparison to HCH Phase 1 Evaluation

- HCH evaluation includes much larger HCH clinic and comparison population
- MN HCH standards guarantee that HCH clinics meet basic criteria for performing as medical homes compared to NCQA model which may not assure that clinics act as a ‘true’ medical home
  - For example, NCQA recognized practices in the pilot did not offer weekend or evening care
  - HCH recognized practices must provide 24/7 access to care
- SQRMS/MNCM quality data
  - Strongly linked to clinics and does not rely on using claims data to attribute patients to clinics
  - Measures intermediate clinical outcomes compared to clinical process measures used in Freidberg, et al. evaluation
- To address further issues, Phase 2 HCH evaluation will conduct full analyses to examine impact and causal effects of the HCH Initiative on access, quality, and costs

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Report available at:

http://www.health.state.mn.us/healthreform/homes/outcomes/evaluationreport.html

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