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

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Agenda

- **11:00-11:05am** – Introductions
- **11:05-11:40am** –
  - Health Care Homes Initiative
  - Highlights from *Evaluation of Health Care Homes: 2010-2012, a Report to the Minnesota Legislature*
- **11:40am-11:55am** – Audience Q&A
- **11:55am-12:00pm** – Closing Remarks

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Today's Speakers

- **Marie Maes-Voreis,** Director, Health Care Homes, State of Minnesota
- **Dr. Douglas Wholey,** Professor, University of Minnesota School of Public Health
- **Moderator:**
  - **Neva Kaye,** Managing Director, Health System Performance, National Academy for State Health Policy

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For More NASHP Resources

Please visit:

- NASHP homepage
  - www.nashp.org
- Medical Homes Map
  - http://www.nashp.org/med-home-map
- Multi-Payer Patient-Centered Medical Home Resource Center
  - www.nashp.org/nashp-multi-payer-resource-center
- Accountable Care Activity Map
  - http://www.nashp.org/state-accountable-care-activity-map
- State Refor(u)m
  - www.statereforum.org

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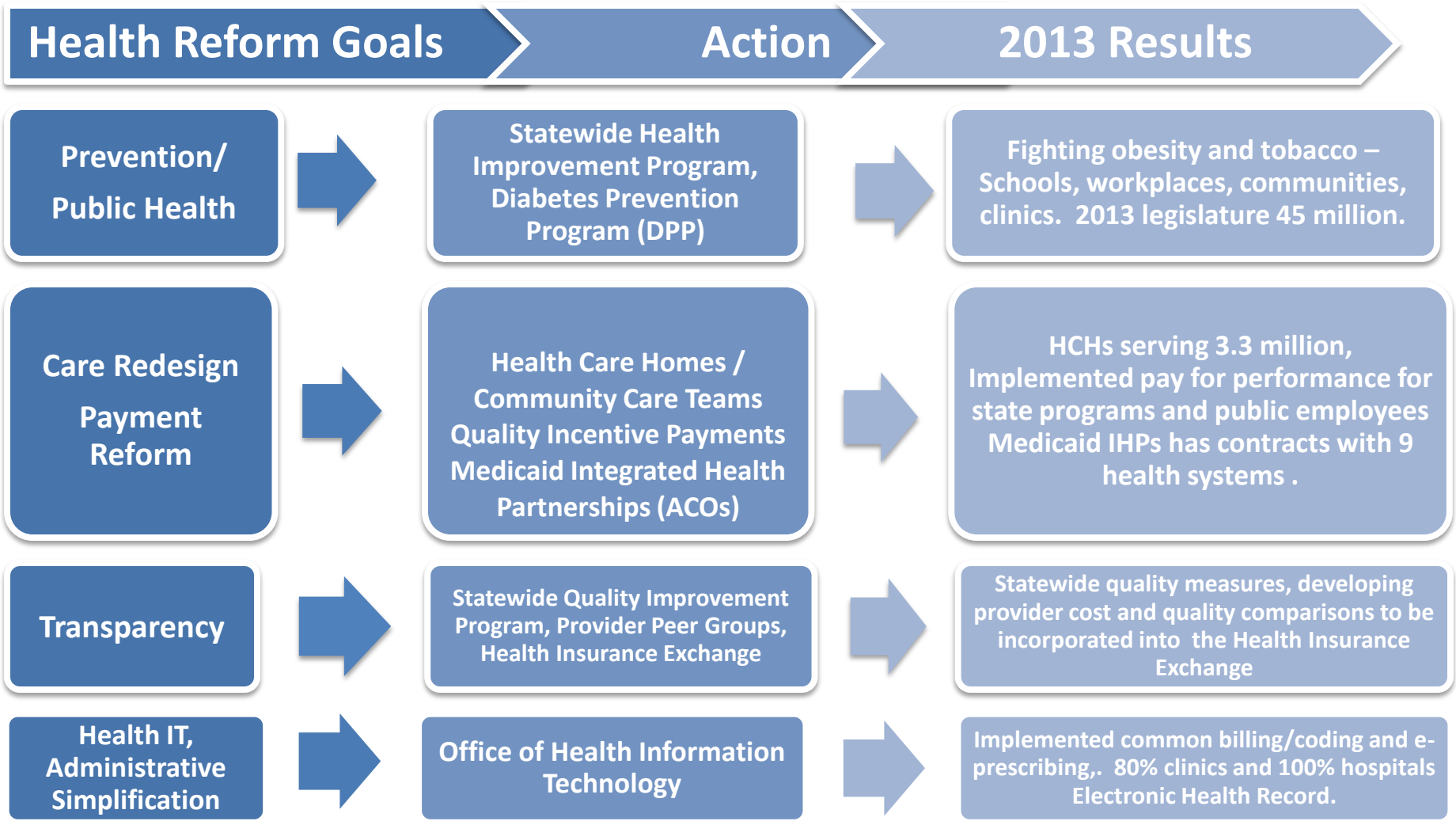
Minnesota Health Reform



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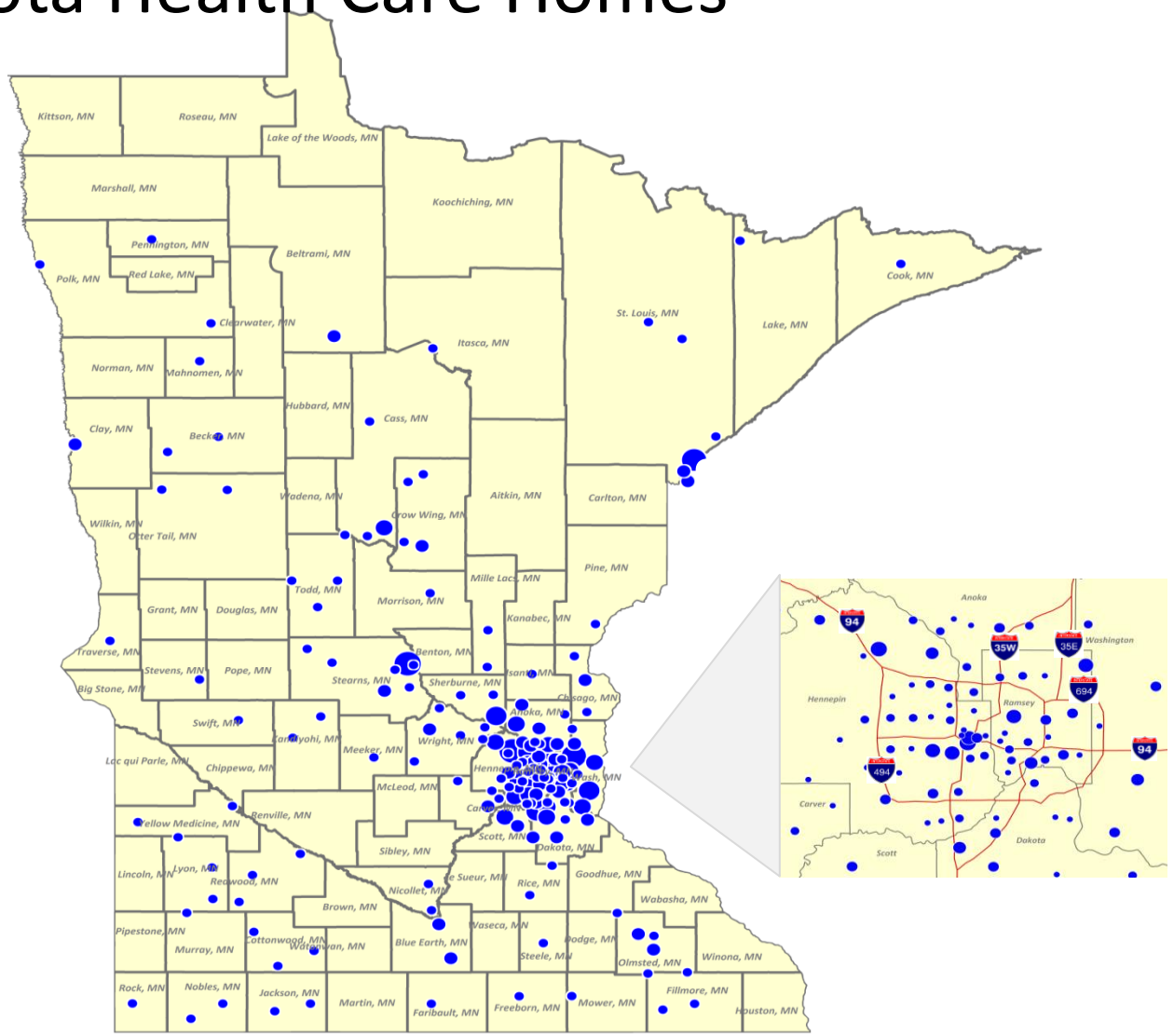
Minnesota Health Care Homes

322 certified HCHs, 42% of primary care clinics

3,429 certified clinicians

Serving 3.3 million Minnesotans



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Health Care Home Implementation Approach

- **Statewide approach, public/private partnership**
- Joint MDH / DHS implementation
- 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
- Builds on a comprehensive statewide HIT / HIE project.
- Outcomes measurement with accountability
- Statewide HCH Evaluation supported by legislation.

Focus on patient- and family-centered care concepts

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Health Care Homes by Region and 2010 Population

Region	Clinics	Certified Health Care Homes	Clinics to Reach 70% Goal	% Region's Clinics Certified	% Counties with One or More Certified Clinics	Clinics per 100,000 People	Certified Clinics per 100,000 People	2010 Population
Metropolitan	334	191	233	57.2%	100%	11.72	6.70	2,849,567
Northeast	62	14	43	22.6%	43%	19.01	4.29	326,225
Northwest	42	8	29	19.0%	38%	20.83	3.97	201,618
Central	90	50	63	55.6%	79%	12.34	6.86	729,084
South Central	57	10	40	17.5%	36%	19.57	3.43	291,253
West Central	36	6	25	16.7%	50%	19.03	3.17	189,184
Southeast	50	16	35	32.0%	64%	10.11	3.23	494,684
Southwest	64	19	45	29.7%	56%	28.79	8.55	222,310
Total MN	735	314	513			13.86	5.92	5,303,925
Border States	21	8						
Total	756	322						

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Standards that Support Development of Practice Tools, All Types of Clinics Participate

Access & Communication
Health care for all, population based.
Same day access
After hours access
Race/Language Data
Preferred Communication

Prepared practice team

Community Partnerships

Activated patient

Quality
Evidence based practice
"Triple Aim" Quality Plan
Quality improvement Team, includes patients/ families
Learning Collaborative
Benchmarking / Evalution

Care Coordination
Collaborative Team
Dedicated time for care coordinator
Panel management
Community resources
Care transitions

Care Plan
Patient Centered Goals
Emergency After Hours Plan
Wellness promotion
Patient self management
Family Involvement
"Refrigerator Ready, Living Document"

Registry
Population Management
Electronic Registry
Prevent GAPS in Care
Pre-Visit Planning

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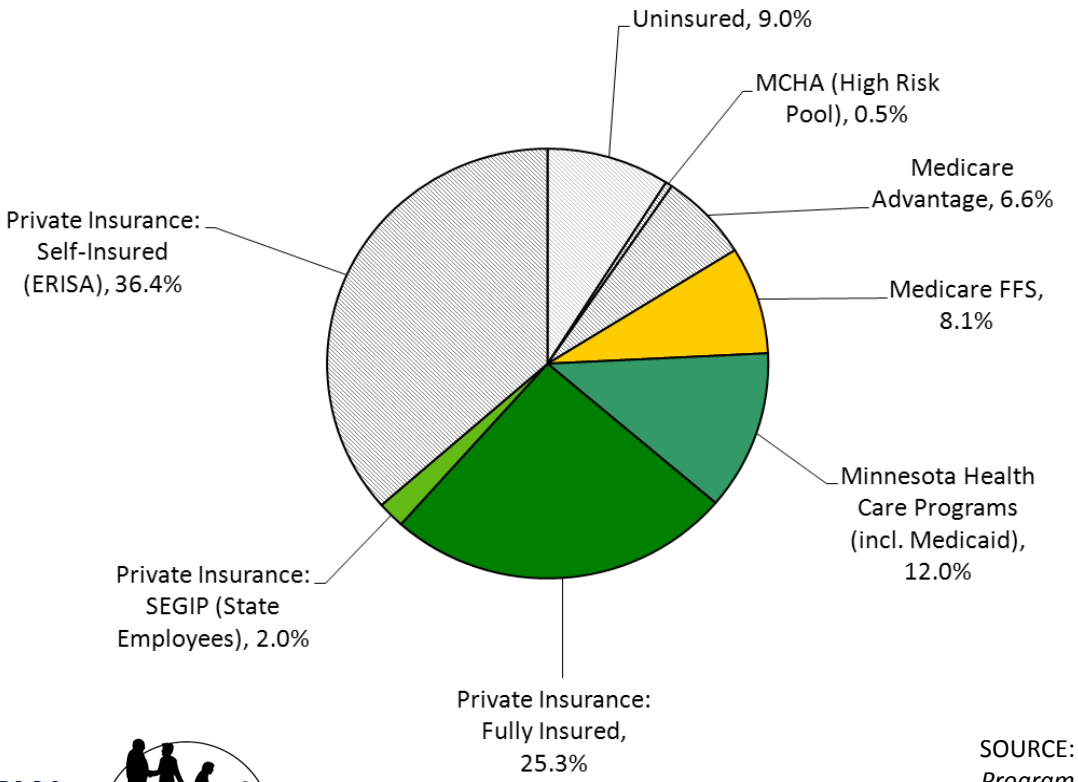
Multi-Payer Investment in Primary Care Transformation

- ***Legislation to promote development of payment methodology***
- ***Focus on "critical mass"***
- ***Started with population management, tiering based on risk complexity***
- ***Foundation to future ACO and TCOC payment methods***



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SOURCE: *Adapted from MDH Health Economics Program, Medicare enrollment data and SEGIP enrollment data*

Performance Improvement

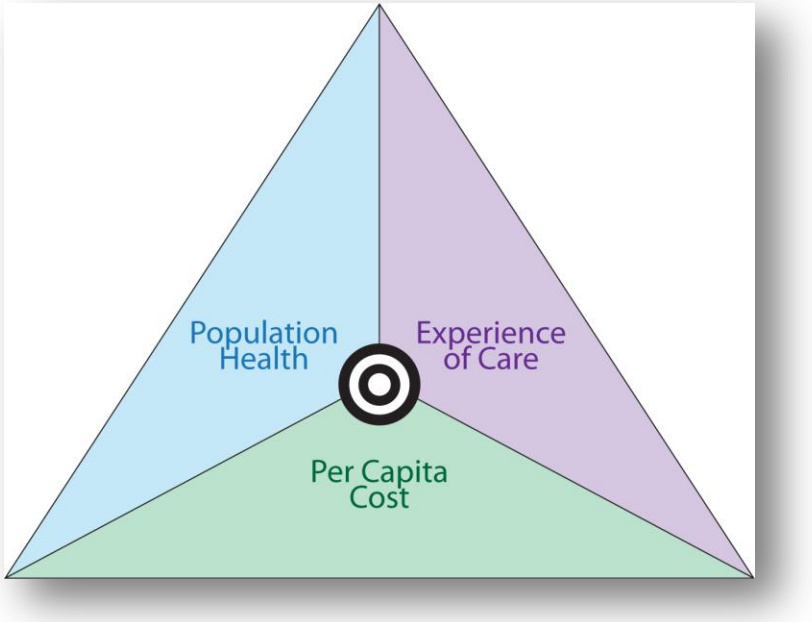
- Included consumers in development of QI processes.
- Build evaluation with triangulation into certification processes.
- Developed benchmarking methodology using statewide quality measures
- AHRQ, Transformation Evaluation
- Legislative Required Evaluation at Years 3 & 5

Minnesota's Three Reform Goals

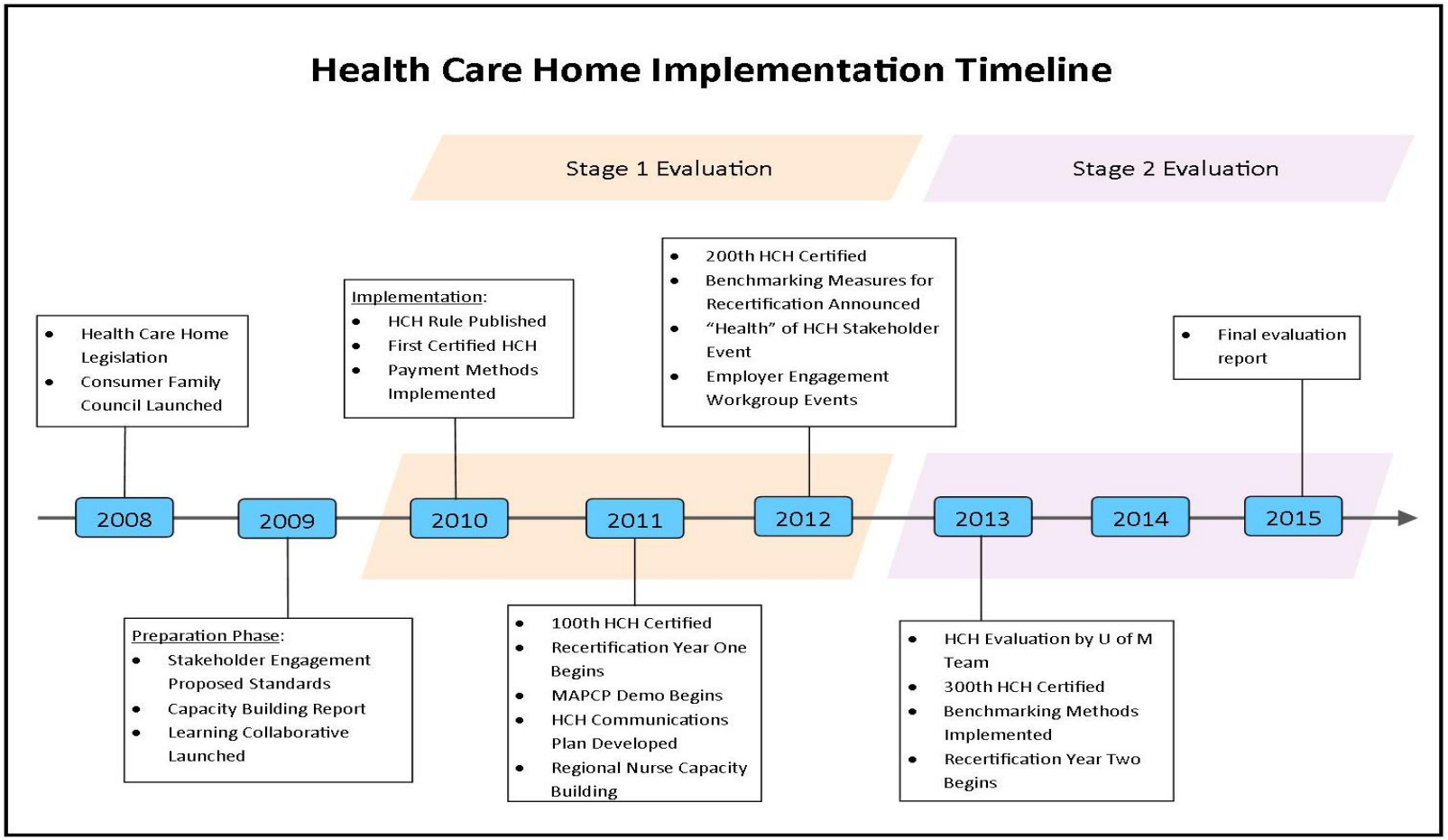
Healthier communities

Better health care

Lower costs



HCH Implementation Timeline



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Health Care Homes Contact Information

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

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

Phase 1 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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Minnesota's HCH Evaluation

- Minnesota legislation directed the Commissioners of Health & Human Services to complete a comprehensive evaluation report of the HCH initiative three and five years after implementation (2013 and 2015)
- University of Minnesota contracted to conduct HCH evaluation
- Phase 1 report completed in early 2014:
  - Describes the implementation and outcomes of the HCH initiative from July 2010 – December 2012 for patients in certified HCH clinics compared to those in non-HCH clinics
- Phase 2 report will be completed in 2015

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2013 HCH Evaluation Report Summary

- The 2013 HCH Evaluation includes:
  - Description of HCH Model
  - Enrollee and Provider Demographics
  - Care Quality
  - Payment Implementation
  - Utilization and Cost Estimates
  - Disparities in Use and Cost
  - Limitations
  - Next Steps

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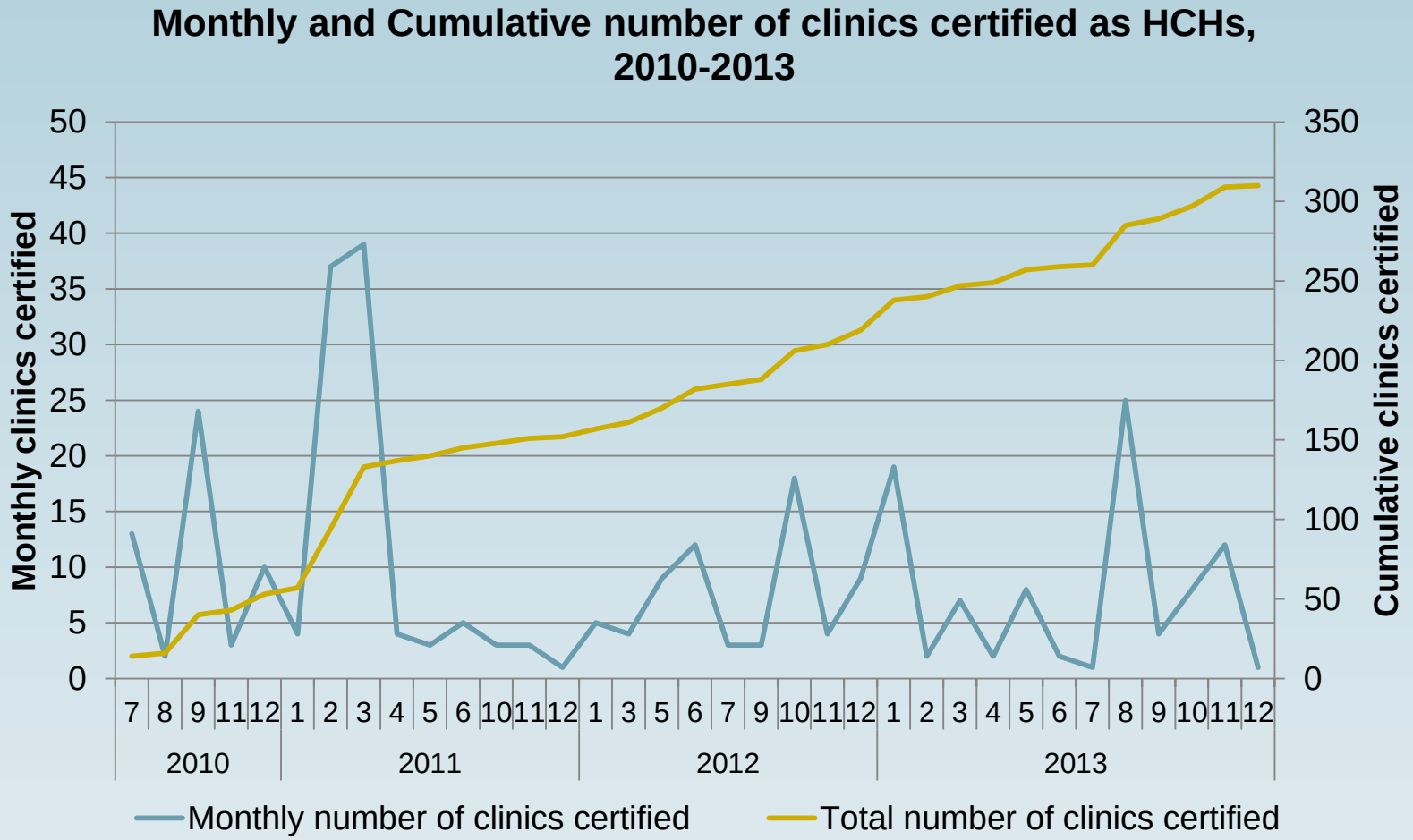
Health Care Homes Phase 1 Evaluation

Methods & Findings

HCH Model: Fidelity and Certification

- Minnesota's 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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Which Clinics Become Certified? Assessing HCH Diffusion

- Unit of Analysis
  - Clinic / Year
- Population & Sample
  - HCH eligible clinics in Minnesota (primary care clinics) – 2009 to 2013 that reported care quality measures to SQRMS/MNCM
  - ~375 clinics per year out of ~760 HCH eligible clinics
- Data:
  - HCH Certification Database for certification date
  - Care Quality
  - Medicaid claims data for 2009 to 2012 with enrollees attributed to clinics
  - Zipcode data
- Method
  - Used logistic regression to regress whether a clinic becoming certified in a year on
    - Lagged quality
    - Clinic size (number of patients reported for quality measures)
    - Average patient PMPY, % of patients by severity tier, % of patients by health insurance tye
    - Whether the clinic was a member of a medical group (defined as a medical group with at least 10 clinics)
    - Median income in geographic area
    - Rurality

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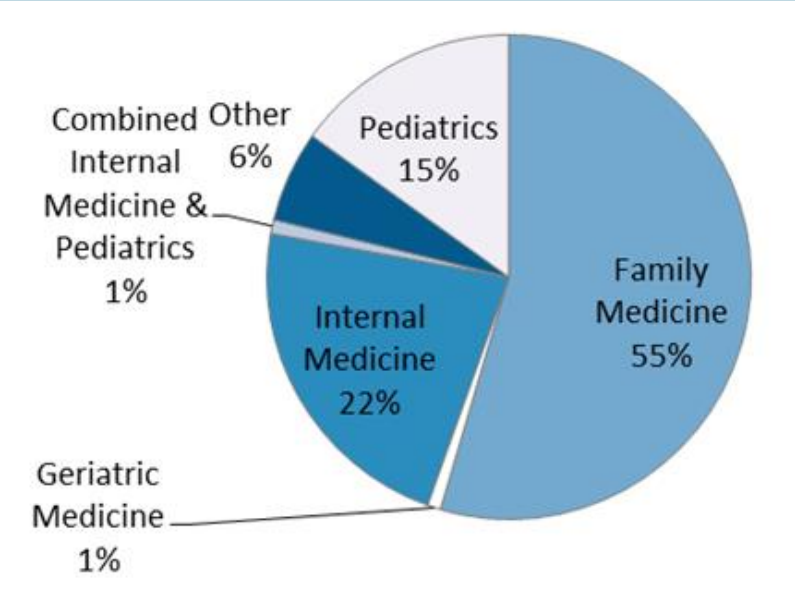
HCH Certification Correlates

- Clinics are more likely to become certified when
  - They have a high care quality in the prior year
  - They have a high percentage of high complexity tier patients
  - They have a high percentage of Minnesota Health Care Plan patients
  - They have a high percentage of Black or Asian patients
  - They serve more patients
  - They are associated with a medical group (10 more clinics)
- Clinics are less likely to become certified when
  - They are located in isolated rural towns

Key Findings: Provider Demographics

HCH providers by specialty, March 2011



- Nearly half of Family Medicine and Pediatrics providers in MN 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

- The number and percent of Medicaid enrollees in 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

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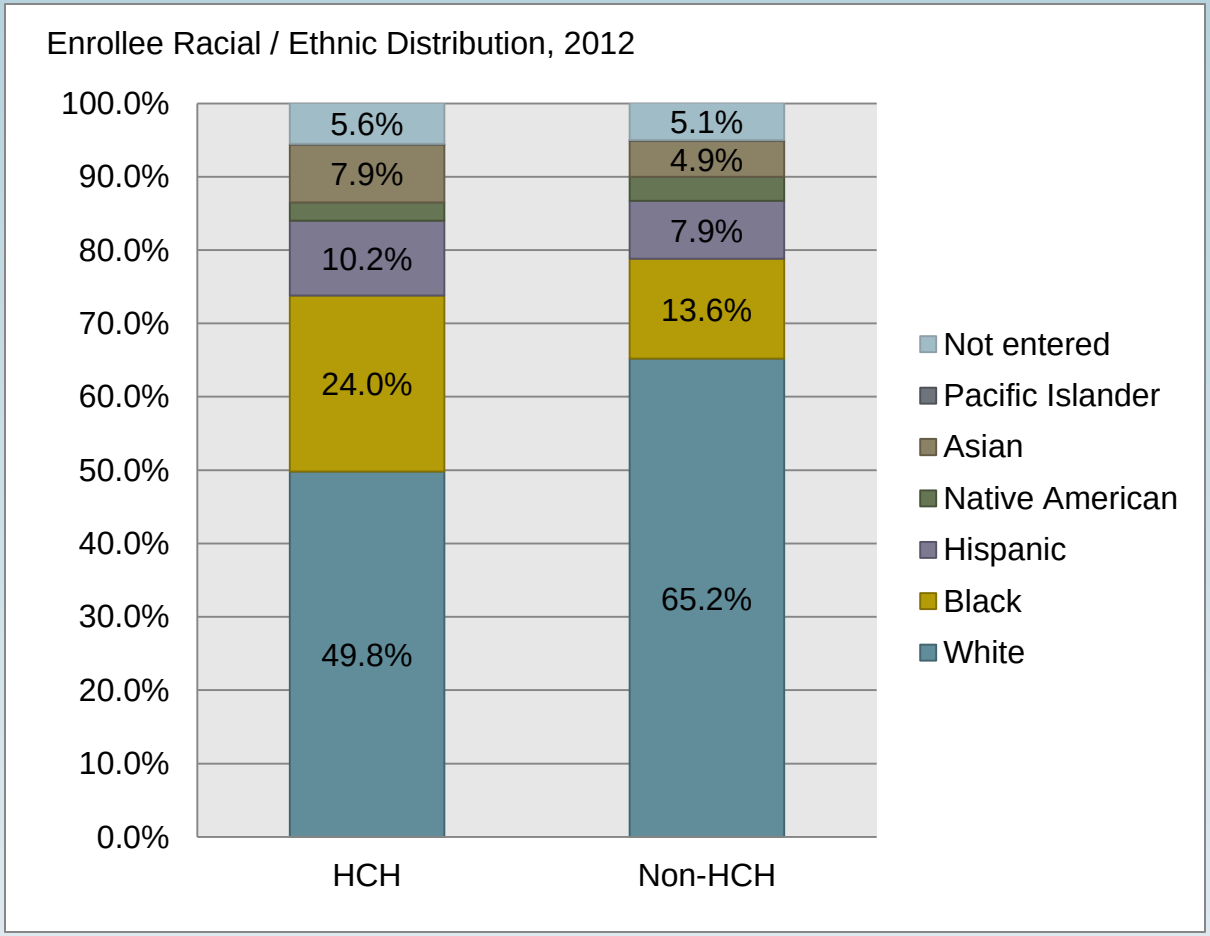
Key Findings: Enrollee Demographics

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



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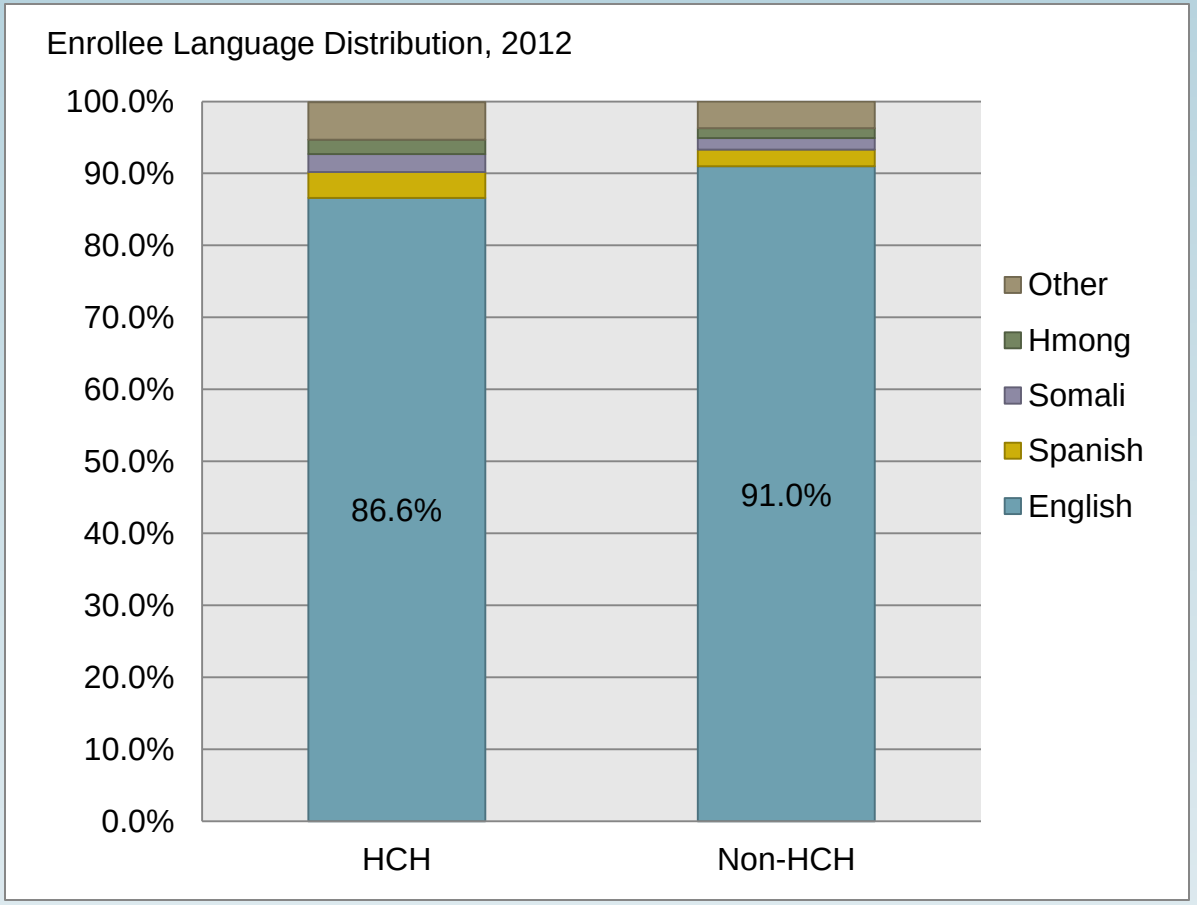
Key Findings: Enrollee Demographics

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



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Assessing Care Quality: Data

- Quality assessments based on the Statewide Quality Reporting and Measurement System (SQRMS) quality data
- SQRMS requires all physician clinics in Minnesota to submit data on quality measures from their Electronic Health Record
- Data are collected and validated by Minnesota Community Measurement (MNCM)
- SQRMS measures include commercial, Medicare, MHCP, uninsured, self-pay patients
- SQRMS Quality Population
  - ~750 HCH eligible clinics included in quality analysis
    - 221 HCH certified clinics
    - Number of clinics included vary by quality measure

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

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Assessing Care Quality: Measures

- Optimal Care Measures:
  - Optimal Diabetes Care, Vascular Care, and Asthma 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:
  - Average Diabetes Care, Vascular Care, Depression Remission at 6 months, Depression follow-up at 6 months, Asthma Care, and Colorectal Cancer Screening 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)

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Assessing Care Quality: Methods

- Initial question: Does quality differ between HCHs and non-HCHs?
  - Initial analysis examined whether HCH quality is different than non-HCH quality with a bivariate analysis
- Subsequent question: Does quality differ between HCHs and non-HCHs taking into account clustering of patients within clinics and clinic self-selection?
  - Preliminary results are presented adjusting errors for clustering by clinic and controlling for
    - Patient characteristics (age, gender, insurance product)
    - Year
    - Correlates of clinic certification self-selection
      - All conditions - square root of number of patients, member of a medical group (system with at least 10 clinics)
      - Lagged clinic average quality for diabetes and vascular

HCHs and Care Quality

✓= HCH had higher quality at .05 significance level		HCH vs. Non-HCH	
		Bivariate Analysis	Adjusting for Clustering and Selection (Preliminary)
Colorectal Cancer Screening		✓	✓
Depression	Remission at 6 months	ns	ns
	Follow-up at 6 months	✓	ns
Asthma Care	Optimal	✓	✓
	Average	✓	✓
Diabetes Care	Optimal	✓	✓
	Average	✓	✓
Vascular Care	Optimal	✓	✓
	Average	✓	✓

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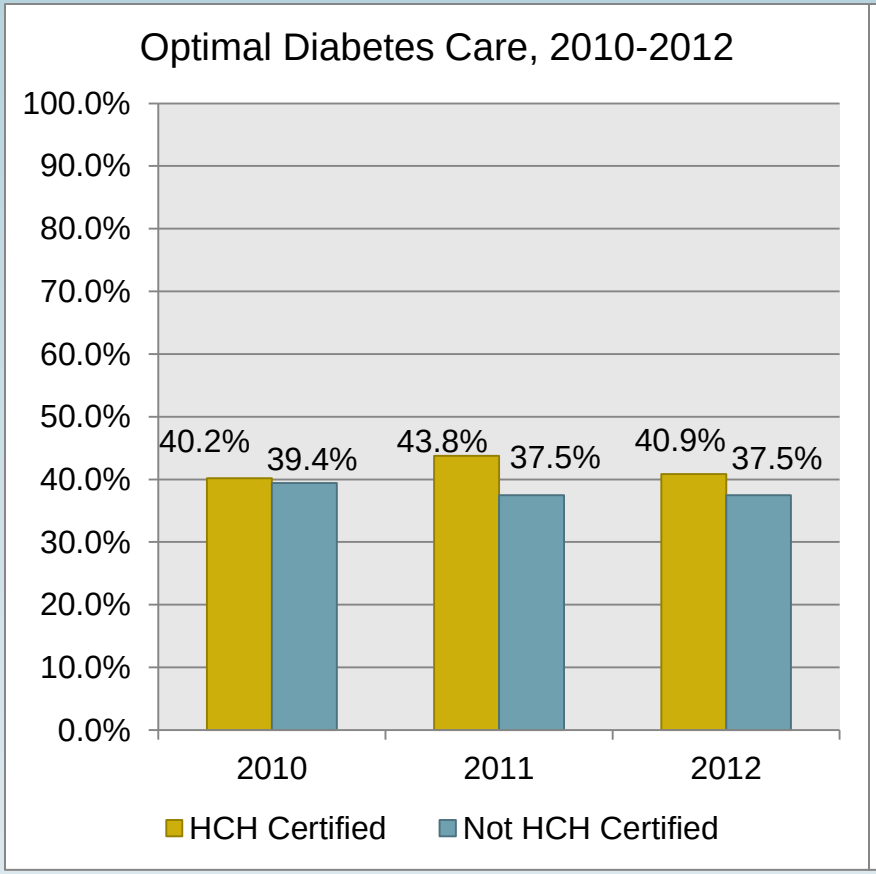
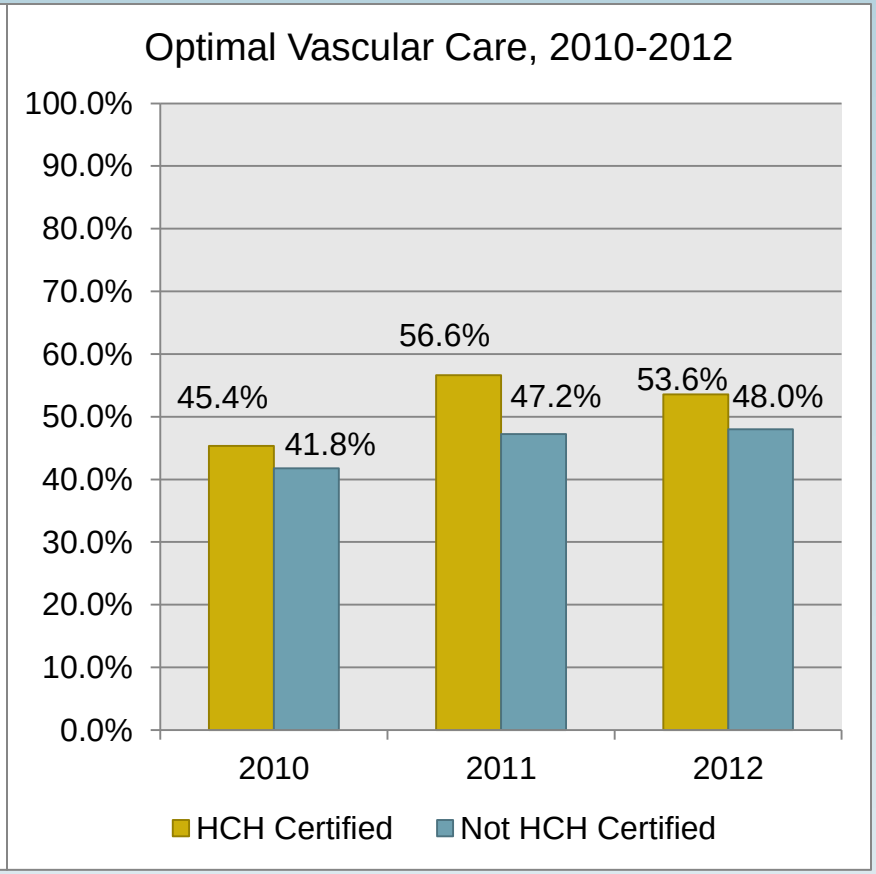
Key Findings: Care Quality (Bivariate)





Differences between HCH and not HCH certified for ODC and OVC optimal measures shown here are statistically significant at p<0.0001.

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Assessing Care Quality: Next Steps

- The Phase 1 report focused on State Quality Measurement and Reporting System measures. Advantages of these data include:
  - Based in primary care EHR
  - Patient-level data collected and reported by primary care clinics
  - Provide clinical values and outcomes which are not present in claims data
- The Phase 2 report will also assess traditional claims-based quality measures
  - HEDIS measures
  - Avoidable re-admissions measures
  - Continuity of care measures

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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

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

Assessing Health Care Utilization and Costs: Methods

- Health care utilization and costs were assessed using Medicaid claims data on Fee-for-service and Managed care patients enrolled in Minnesota Health Care Programs (MHCPs) in 2010-2012.

- Difficult to assess trend in costs/utilization over time due to:
  - Attribution – Improved percentage of enrollees attributed to clinics in 2012
    - 2010: 5.0 % of patients
    - 2011: 5.8 % of patients
    - 2012: 27.3 % of patients
  - Differences due to
    - Changes in clinic type adopting HCH over time, e.g. early adopters included clinics with high risk populations such as FQHCs, and
    - Patient characteristics, e.g. more complex patients with more encounters more likely to be attributed in earlier years
    - Increasing availability of data associating providers with clinics

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Key Findings: Estimated Costs

- HCH Medicaid enrollees had higher health care costs during 2010 and 2011, but lower costs than non-HCH enrollees by 2012
- 2012 total health care costs (Average Medicaid expenditures per enrollee per year):
  - enrollees attributed to HCH: **$2,372**
  - enrollees attributed to non-HCH primary care clinic: **$2,506**
- Combining data for all 3 years (2010-2012), we see lower costs for HCH enrollees

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Key Findings: Estimated Costs & Cost Savings

- 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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What may contribute to lower costs for HCH?

- Trends in utilization may help us understand why Medicaid enrollees receiving care in HCHs have lower costs.

Comparison of services used (2012)

Service	HCH attributed enrollees (compared to non-HCH)	Comparison of HCH vs non-HCH
E&M encounters	Fewer average encounters	5 in HCH vs 5.6 in non-HCH
Emergency Dept visits	Fewer average visits Same average costs	Visits: 0.87 for HCH vs. 0.89 in non-HCH Cost: $74 for both
Hospital inpatient stays	Same average number of stays	0.024 for HCH and non-HCH
Hospital outpatient encounters	Same average encounters Lower average costs	Encounters: 1.3 for both Cost: $109.70 for HCH vs. $124.29 for non-HCH
Professional services	Higher average costs	$1,246.67 for HCH vs. $1,155.29 for non-HCH
Pharmacy	Lower average costs	$583 for HCH vs. $672 for non-HCH

- We will further explore the mechanisms for the association between HCH and decreased costs in Phase 2 of the evaluation.

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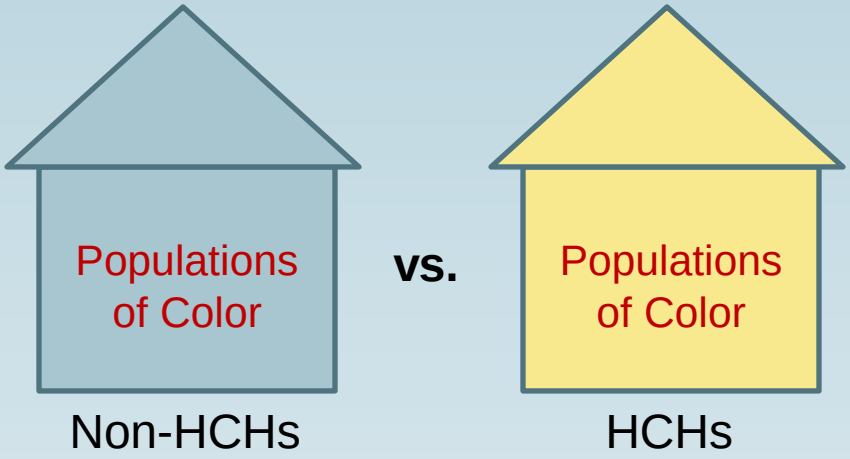
Key Findings: Disparities in Care

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

Key Findings: Disparities in Care

- 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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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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Thank You!

Phase 1 HCH Evaluation Report available at:
http://www.health.state.mn.us/healthreform/homes/outcomes/evaluationreport.html

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