

Health Care Home Payment Methodology:

Structure and Design



*Health Care
Homes* | **HCH**

Minnesota Department of Human Services
Minnesota Department of Health

January 2010



Minnesota Department of **Human Services**



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Executive Summary

The Health Care Homes portion of Minnesota's 2008 Health Reform law requires the Minnesota Departments of Human Services and Health (DHS and MDH) to develop a system of per-person care, risk-stratified coordination payments to certified Health Care Homes (HCH). This payment methodology applies directly to the Minnesota Health Care Programs (MHCP), and other affected payers (including the state employee group insurance program and state-regulated private health plans) are required to implement a payment system "in a manner that is consistent with" the public programs. DHS and MDH consulted extensively with a variety of health care stakeholders throughout 2009 to develop the payment methodology, which is described here.

The payment methodology categorizes patients into "complexity tiers" based on the number of major chronic condition groups (such as cardiovascular, respiratory, and endocrine) identified by the provider treating them in the HCH. Providers identify patients and assign a tier level for payment based on common requirements, and payers can audit the basis for tier assignment and the work associated. If the patient has a language barrier or a serious mental illness, these supplemental factors each garner a defined-percentage increase in the payment rate associated with each tier.

The HCH practice will develop a process to determine which patients are eligible for payment and at which tier level. They will then submit a claim using a set of defined procedure codes and modifiers linked to the patient's tier level. Billing will occur on a monthly basis, and the patient's complexity level should be reassessed annually at a minimum.

From the patient/consumer perspective, a number of issues should be considered. Particularly in commercial insurance products, HCH payments should be exempt from patient cost-sharing such as deductibles, co-payments and coinsurance wherever possible. It is desirable for the HCH to be integrated into the patient's experience in the clinic, and non claims-based payment arrangements should be considered as the initiative evolves. Communication strategies regarding the patient's role and the benefits of the Health Care Home will be crucial to the success of this effort.

With the initial design work complete, DHS will develop rates for the complexity tiers and seek approval from the Centers for Medicare and Medicaid Services (CMS) to implement them in MHCP. DHS and MDH will continue to seek stakeholder input as the payment methodology is implemented and refined over time.

Introduction and Background

Health care homes, also nationally known as medical homes, are a cornerstone of the comprehensive, nation-leading health reforms passed in Minnesota in 2008. Health Care Home (HCH) is a model of primary care in which primary care providers, families and patients work in partnership to improve the health and quality of life for individuals, especially those with chronic and complex conditions. 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 development of Health Care Homes in Minnesota is driven by the Institute for Healthcare Improvement's Triple Aim¹, an initiative to simultaneously achieve the following goals:

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

Medical home legislation was first passed by the Minnesota Legislature in 2007, and applied only to very complex fee-for-service public program enrollees. The broader 2008 health reform law included provisions to develop Health Care Homes, including the development of outcomes measurements, standards and criteria for certification and a payment methodology. 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 health promotion.

The 2008 law builds on the momentum of the HCH concept – and benefits from broad agreement on its potential to transform primary care delivery, create more patient- and family-centered care, and catalyze changes to the entire model of health care delivery. The Minnesota Departments of Health (MDH) and Human Services (DHS) are collaborating to implement the various aspects of health care homes in Minnesota in close partnership with stakeholders from across the health care system.

The structure of the HCH initiative is made up of a statewide certification process (housed at MDH) and a linked multi-payer payment methodology. Through a carefully-developed common definition of what constitutes a health care home, only providers and clinics that have been certified are eligible for the care coordination payments called for in the legislation. (The full version of the HCH legislation related to payment is attached as *APPENDIX A*.) The legislation requires DHS and MDH to develop a system of per-person care coordination payments to certified health care homes for the Minnesota Health Care Programs (both fee-for-service and managed care), with fees varying by patient complexity. These care coordination payments are to be implemented on 7/1/10 or upon federal approval. The state employee group insurance

¹ Institute for Healthcare Improvement. <http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>

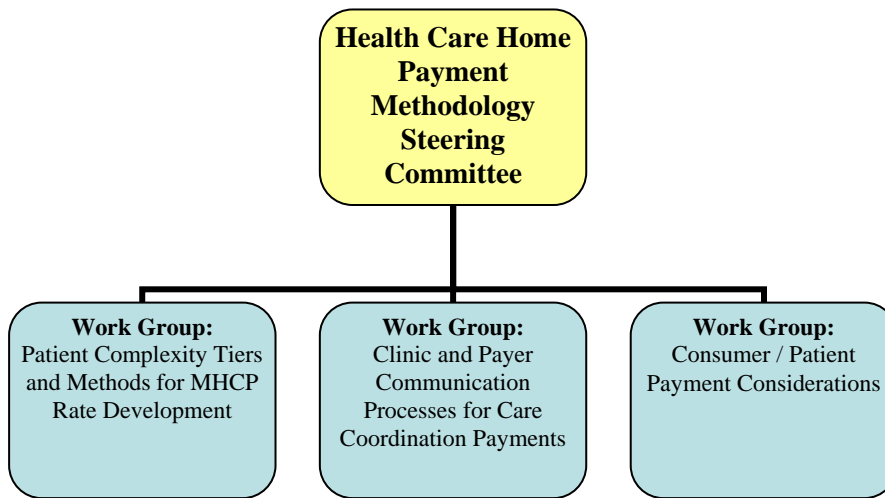
program as well as private health plan products regulated by the state are also required to implement care coordination payments by 7/1/10 “in a manner that is consistent with” the system developed for the public programs.

The HCH initiative is multi-payer by definition, and in the development of this payment methodology stakeholders consistently articulated the goal of achieving a “critical mass” of payment that will enable the delivery system to transform. That is: no one payer can sufficiently realign incentives alone, and the wholesale practice transformation called for in the HCH model is expected to improve care for all patients regardless of payer. In this spirit of collaboration and mutual investment in the outcomes of HCH, stakeholders and state government staff set out to design a payment methodology that would create sufficient alignment across payers, minimize administrative burden for all involved, and serve as a crucial first iterative step toward the system-wide transformation envisioned in the HCH model. The payment methodology that follows is the result of that work.

Stakeholder Input Process

The development of the payment methodology was based on collaboration and partnership among stakeholders. This was accomplished through the creation of a Health Care Home Payment Methodology Steering Committee to provide strategic guidance and a series of three work groups to focus on the more detailed and operational components of the methodology. Each of these groups was composed of nominated representatives from provider, payer, consumer, and quality organizations, and supported by an assigned state government staff person. (Complete membership listings for the steering committee and work groups are attached as *APPENDIX B*.) The stakeholder input structure is illustrated in *Figure 1* below.

Figure 1: Steering Committee and Work Group Structure



The work of the Steering Committee was further guided by feedback gathered more broadly from the public.

- At a public meeting held in April of 2009, approximately 60 stakeholders gathered to discuss and assess a set of Health Care Home Payment Methodology Principles. These principles garnered broad support as assessed by a real-time electronic polling mechanism, and served as a guide for the work going forward. The principles are attached as *APPENDIX C*.
- After the work groups and steering committee completed a draft set of payment methodology recommendations, a second public meeting and presentation was held in November of 2009. This event opened a period of written public comment, which was shared with the steering committee to further refine the payment methodology.

A project chart illustrating the timeline for the stakeholder input process is attached as *APPENDIX D*.

Payment Methodology Components

Patient Complexity Tiers

Overview and Objectives

The Health Reform legislation requires DHS and MDH to develop a system of per-person care coordination payments to certified HCHs, and specifies that the payment must vary based on the complexity of the patient. The law also states that the agencies must consider the inclusion of factors such as “limited English-language skills, cultural differences, or other barriers to health care” in how it defines patient complexity and care coordination need. The objectives of designing the patient complexity tiers were two-fold:

- To define the currently non-billable work of care coordination in a HCH² as the basis for how patients will be grouped based on the estimated time and work required to coordinate their care.
- To create a system to group all patients in a population into objectively verifiable “complexity tiers” based on how much care coordination they are expected to need over a given time period to achieve or maintain optimal health.

The literature is relatively sparse on how much time and work are required to coordinate care in the primary care setting for patients of varying complexity. Therefore, it is necessary to draw on analysis of administrative (health care claims and enrollment) data to describe how patient complexity varies in a population. This means using diagnosis, health care utilization, and resource use (costs) as proxies for overall care coordination need. Although these data can be useful, they do not tell the entire complexity story. Claims systems designed for payment are limited in their clinical content, and high-cost patients are not necessarily those in greatest need of care coordination. Therefore, the patient complexity tiers draw on a combination of data analysis, clinical input, and local and national expert opinion. Continued research will be needed to evaluate and adapt the current model over time.

One of the core payment methodology design principles was that the HCH practice itself would identify patients and determine patient complexity for payment, as opposed to each individual payer defining the patients to be served and their payment level. This necessitated a system in which the basis for each patient’s tier assignment would have face validity to providers and be able to be implemented in the clinic, and also be objectively verifiable and auditable by the payers administering the HCH payments. The multi-payer system of complexity tiers is also intended to decrease the administrative burden on both providers and payers by setting common

² Work group recommendations defining the currently non-billable tasks and functions of care coordination are attached as *APPENDIX E*.

definitions for the coding and billing of care coordination services. HCHs will be given standards and guidance on how to assign complexity tiers, as well as tools to support this process.

Complexity Tier Structure

The tiers include two sets of patient complexity factors:

- **Chronic Condition Count:** The number of chronic conditions affecting the individual patient forms the basis of tier assignment. Stakeholder input highlighted the value of using diagnoses as the core of the tier structure based on their relationship to both resource use and care coordination need. It was an overt strategy to consider patterns of past health care utilization (such as specialty care use or ED visits) as program outcomes rather than the basis for payment. This ensures that desirable changes in utilization, such as reduced avoidable hospitalizations, would not result in reduced reimbursement for the HCH practice that is coordinating care.

Stakeholders pointed out that some conditions are likely to require more care coordination than others based on their chronicity and severity. Because providers will be doing tier assignment, there must be a practical and reproducible way to define and group conditions that does not require categorization down to the individual diagnosis code. However, the tiering system must also create sufficient distinctions between co-morbid conditions to reflect the added care coordination effort of each. The compromise solution reached was to count “major condition groups” (such as cardiovascular, respiratory and endocrine) that providers identify as:

- **severe,**
- **chronic, and**
- **requiring a care team for optimal management.**

The tier structure is as follows:

Tier Zero: No Major Condition Groups³

Tier 1: 1-3 Major Condition Groups

Tier 2: 4-6 Major Condition Groups

Tier 3: 7-9 Major Condition Groups

Tier 4: 10+ Major Condition Groups

- **Supplemental Factors:** A number of additional factors were considered for inclusion that do not necessarily predict health care resource use but are thought to increase the

³ Patients in this group may have no chronic conditions, or may have one or more chronic conditions that are not considered major.

need for care coordination⁴. Because of their presence in administrative data and ability to be objectively verified, two factors were included in the payment methodology as a starting place:

- **Primary language other than English**
- **Serious and persistent mental illness⁵**

These factors will be assessed by the providers based on standardized definitions/guidance, and each will garner the same defined-percentage increase in the payment rate for each tier to reflect their contribution to patient complexity. As the methodology evolves over time, additional supplemental factors will be studied and considered for inclusion.

Tools to Support Provider Tier Assignment for Appropriate Coding

As stated above, the payment methodology is designed around providers identifying patients and assigning them to a complexity tier for care coordination payment based on the count of major conditions. As such, tools must be developed to support this tier assignment in the HCH to ensure consistent and appropriate coding based on patients' tier level and supplemental factors. This can be described as analogous to the coding instruction for evaluation and management (E&M) visits at varying levels: some consistent process is expected for appropriate coding, but the justification for each coding decision need not be submitted for each payment. These tools could take a number of forms depending on the Health Care Home need:

- A paper tier assignment tool with a scoring system. (An early draft of a possible tier assignment tool is attached as *APPENDIX F*.)
- An electronic version of the paper tier assignment tool that calculates the patient's tier level based on the information entered.
- A web-based tool that provides an estimate of the patient's tier level based on a provider-entered list of diagnoses and/or the payer's administrative data.

There will be additional input and testing of the tools needed to support provider tier assignment, with a focus on clear instructions and verification of the tool's consistency.

⁴ In rank order of importance, the top supplemental factors identified were: readiness to change/engage in care, primary language, mental health/behavioral health conditions, access to communication tools, social support, and employment/education.

⁵ It is worth noting that mental health conditions are also counted as major conditions for tier assignment. Their inclusion as a supplemental factor as well reflects the impact that these conditions have on the overall care coordination time and effort regardless across all conditions.

Current Look at Complexity Tiers Using MHCP Data

In order to determine appropriate complexity tier boundaries and to estimate how providers will determine complexity across a population, a data model was constructed using Minnesota Health Care Programs (MHCP) claims data. The construction of this model involved grouping patients based on the type and nature of their diagnoses, and allowed for comparisons of health care spending patterns across various tier scenarios. Using modifications of the Johns Hopkins ACG risk adjustment system, the following tier estimates were produced to model how the complexity tiers may look in the MHCP population. Since the models were produced using solely administrative data, it will be important as the payment methodology develops to measure and understand the differences between providers' complexity assessment and the complexity information available to payers from diagnoses in the claims system.

Figure 2 below illustrates the estimated distribution of the fee-for-service MHCP population in state fiscal year (SFY) 2008 based on the count of major condition groups⁶.

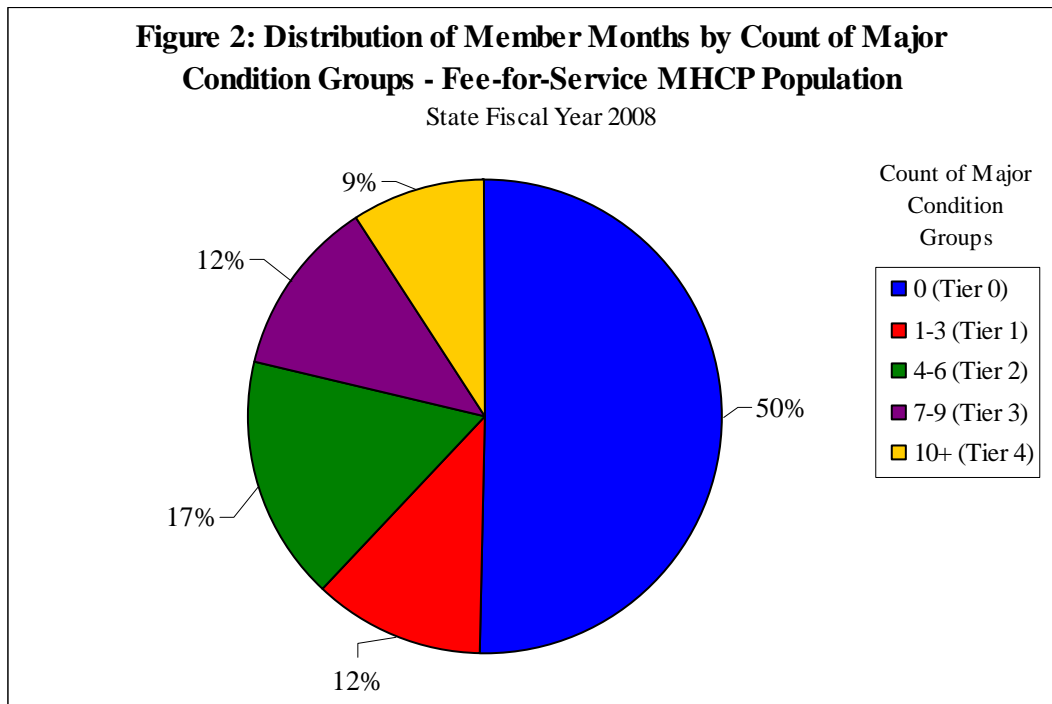


Figure 3 below illustrates the mean and median cost values for each complexity tier. As expected, total expenditures increase with a higher number of major condition groups.

⁶ The estimated major condition group counts were calculated using a combination of two ICD-9 categorization schemes produced by the ACG software: Major Expanded Diagnosis Clusters (EDCs) and Major Aggregated Diagnosis Groups (ADGs).

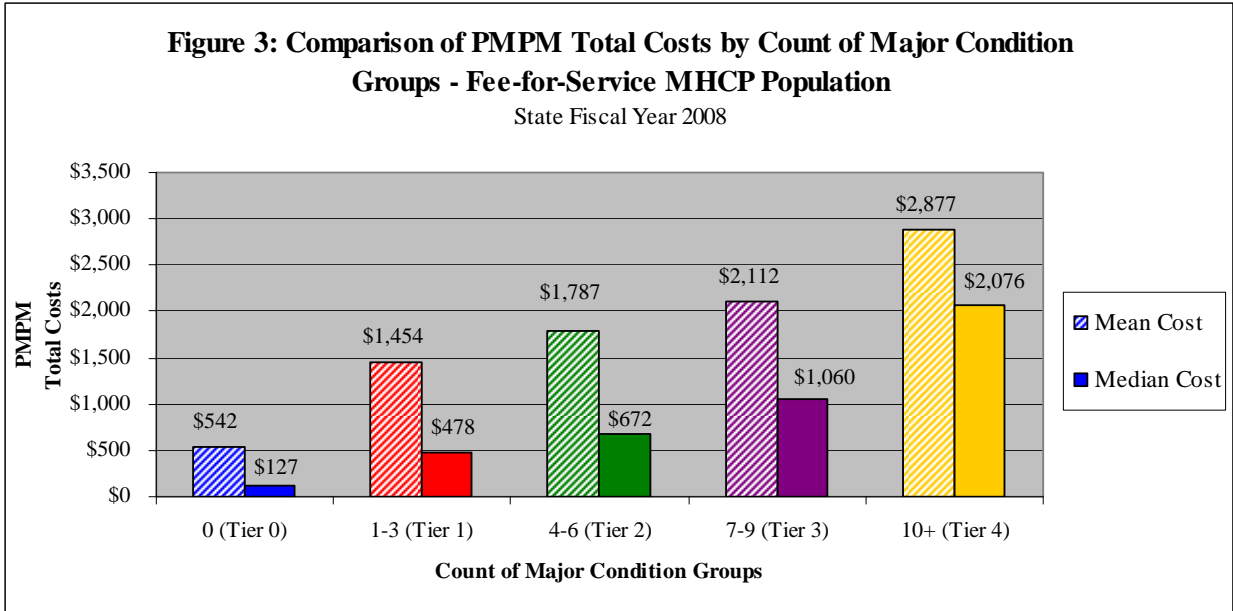
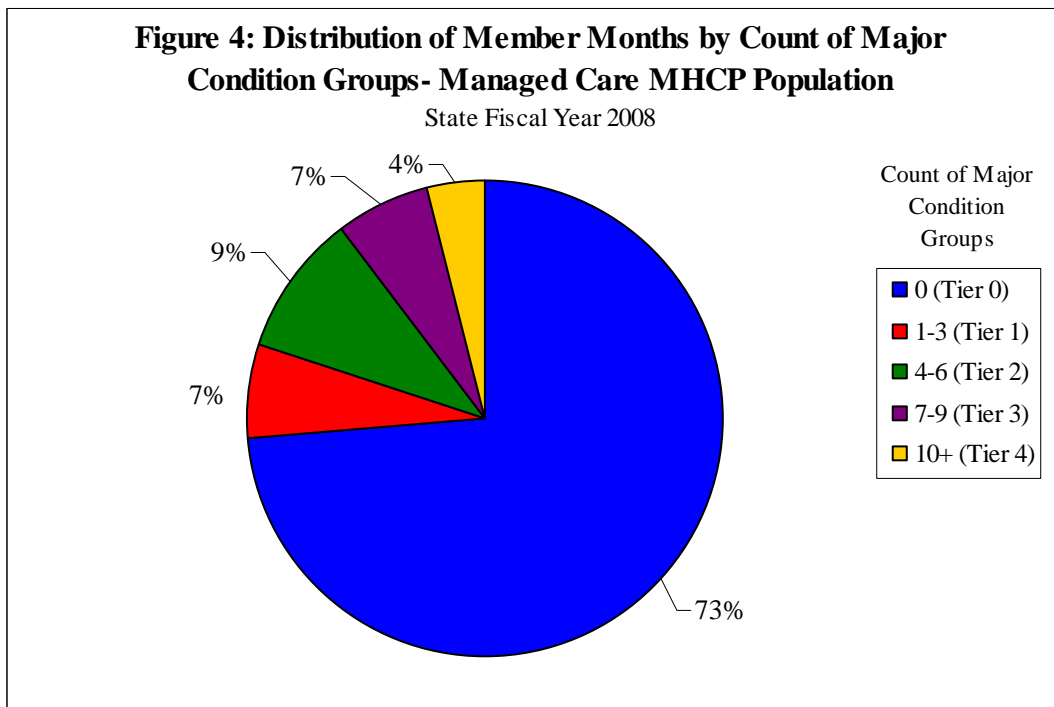


Figure 4 below illustrates the same estimated distribution for the MHCP population enrolled in a managed care plan. As expected, the MHCP population in managed care shows a different distribution because of the lower overall disease burden compared with fee-for-service. Cost data for these managed care populations are not routinely available to DHS.



Clinic and Payer Processes for Payment

In addition to the use of common complexity tiers, it is important that the administrative processes for payment are clearly defined. This includes the processes by which a HCH will assign patients to a complexity tier and alert the appropriate payer, the development of standard coding and billing conventions, and definitions of required documentation for billing. The payment process recognizes the importance of creating consistency for participating HCHs by utilizing the submission of claims through existing systems for care coordination payments. This was identified as the most appropriate near-term process for payment across multiple payers under the legislative requirements, while a number of other non-claims-based payment mechanisms were identified for future consideration.

Key Clinic Process Steps

In order to bill for care coordination payments for services provided, the HCH will:

- Implement a method to determine whether the patient's complexity level makes them eligible for a care coordination payment using a screening method, patient registry, or supporting tools made available by DHS.
- Determine and assign the patient's complexity tier, and the corresponding procedure code modifiers.
- Identify the patient's payment source and determine whether their insurance coverage includes a HCH care coordination payment.
- Inform the patient about the HCH, what it means to the patient, the potential benefits, and recommendations from the clinician and the patient's payment eligibility. Seek the patient's input during the discussion that results in shared decision making about the patient's engagement and participation in care coordination.
- Document the decision of whether the patient agrees to participate in care coordination in the medical record.
- Document the agreed-upon start date for care coordination in the medical record.
- Flag the patient's complexity tier and willingness to participate in care coordination in the medical record system where all team members can access the information.
- Develop an ongoing tracking mechanism for care coordination billing.
- Re-evaluate each patient's complexity tier annually, or more often if warranted by a change in the patient's condition.

Participant Agreement

The discussion and agreement by the patient to participate in care coordination is the trigger to starting the payment process. There is an activation / engagement action in place with documentation of the event. This could occur through phone, email or face-to-face contact. The

start date for billing starts with the patient’s agreement to participate in care coordination and identification of the complexity tier.

Billing Process

The billing process is based on existing claims systems. The HCH will use the procedure codes and modifiers recommended by the Administrative Uniformity Committee (AUC). The recommendations of the AUC⁷ include the use of two new HCPCS codes for medical home services, and a series of modifiers to indicate the patient’s complexity tier level and the presence of the two supplemental complexity factors.

HCPCS Codes				
S0280	medical home program, comprehensive care coordination and planning, initial plan			
S0281	medical home program, comprehensive care coordination and planning, maintenance			
Modifiers				
Tier	Patient Complexity Level		Primary Language Non-English	Severe and Persistent Mental Illness
0	Low	(no modifier)	U3	U4
1	Basic	U1	U3	U4
2	Intermediate	TF	U3	U4
3	Extended	U2	U3	U4
4	Complex	TG	U3	U4

Using these codes and modifiers, the HCH submits a claim for one unit per month per patient. The claim can be submitted to the payer at any time during the month for the full month’s payment, and monthly payments will not be prorated by the number of days in the month. Care coordination services can be billed on a claim with other services. Billing is done based on the statewide claim transaction standards as defined by MN Statutes, 62J.

Because of the need for payers to verify that only certified HCH clinicians receive this payment, the rendering or treating provider listed on the claim line for care coordination must be a certified HCH clinician.

Insurance Eligibility

The HCH can decide whether or not they want to check insurance eligibility prior to claim submission for care coordination payments. The payers’ eligibility portals should include a HCH benefits designation for efficient and reliable eligibility checking by Health Care Homes.

⁷ The AUC recommendations also include a longer-term, more optimal solution involving new modifiers and/or condition codes. This will involve requesting codes from national organizations, and has the potential to improve on the interim solution proposed above.

Remittance Process

To ensure accurate payment and to avoid claim denials, the HCH will develop and maintain a process for tracking ongoing care coordination as follows:

- The HCH will develop an internal process for communication between the clinical staff and the finance staff to stop the monthly claim process when the patient is no longer receiving care coordination services.
- The HCH will develop a remittance process based on MN 835 and 62J for Claim Adjustment Reason Code (CARC) or Remittance Advice Remark Code (RARC).
- When a claim is denied because another HCH is already providing care coordination services to a patient, the following remark codes should be used per AUC recommendations: **B20** (CARC) or **N472** (RARC).
- The HCH will establish a communication process whereby, in the case of a care coordination claim denial, billing staff notify clinical staff (such as the care coordinator) of the denial and a HCH team member discusses the issue with the patient.

Notification to Payer (“Enrollment”)

The notification of the payer by the clinic of the patient’s agreement for care coordination is triggered by the submission of a claim that includes the S0280 code with appropriate modifiers for complexity tier and supplemental complexity factors (if applicable). There should also be supporting documentation in the patient’s medical record.

Documentation Requirements

Care coordination requires a reasonable level of documentation that provides evidence that the patient is being actively managed based on the HCH certification requirements and the patient’s defined complexity tier. Documentation is based on the patient’s complexity tier and the required work for that complexity tier consistent with the HCH standards

Documentation requirements for care coordination include:

- For all HCH participants:
 - Standard preventive maintenance and the patient’s preferred mechanism of communication.
 - Basic medication reconciliation to avoid interactions or duplications.
 - Ongoing support, oversight and guidance by a primary clinician and team.
 - Patient’s understanding of access to the clinic and after hours plan.
 - Routine clinic panel or registry management and tracking of hospital and other admissions.
 - Evidence based guidelines are implemented and there is staff monitoring to ensure use of evidence-based guidelines and clinical decision making to facilitate diagnostic test tracking, pre-visit planning and after visit test / set follow-up.

- For more complex HCH participants (as pre-determined by the HCH practice):
 - There is review of medication changes occurring outside of an E/M visit.
 - Designated primary care provider and care coordinator are documented.
 - Individualized, active care plans are in place with ongoing updated goals.

For each identified step in the billing process, the HCH will maintain appropriate documentation as follows:

Key Process Step	Documentation Recommendation
Implement a method to determine whether the patient’s complexity level makes them eligible for a care coordination payment using a screening method, patient registry, or supporting tools made available by DHS.	The screening documentation is noted in the medical record. The documentation options are a pre-defined standardized tool, the registry, documentation template such as a smart phrase, a flow sheet, or an order set.
Determine and assign the patient’s complexity tier, select the appropriate procedure codes and modifiers.	The patient’s complexity tier is noted in the medical record in a location where the health care team and specialty providers can see the patient’s Health Care Home status and complexity tier. In addition, the complexity tier is documented in the billing system.
Identify the patient’s payment source and determine whether their insurance coverage includes a HCH care coordination payment.	Insurance eligibility is documented in the clinic’s usual manner.
<p>Inform the patient about the HCH, what it means to the patient, the potential benefits, and recommendations from the clinician and the patient’s payment eligibility. Seek the patient’s input during the discussion that results in shared decision making about the patient’s engagement and participation in care coordination.</p> <p>Document the decision of whether the patient agrees to participate in care coordination in the medical record.</p> <p>Document the agreed-upon start date for care coordination in the medical record.</p> <p>Flag the patient’s complexity tier and willingness to participate in care coordination in the medical record system where all team members can access the information.</p>	The HCH has established a procedure with standards in place for this process/discussion. There is documentation that this discussion occurred. It may be as simple as “HCH discussion patient agrees/disagrees to participate in care coordination.” A variety of tools can be used for this documentation.

Billing Audits

Care coordination payments audits will be implemented using standard auditing processes that health plans currently have in place. Audits will be designed to assure that providers' tier assignment is generally consistent with diagnosis coding elsewhere in the claims system, and that patients are receiving a level of care coordination appropriate for their designated tier level. As the program moves forward, stakeholders will be consulted for further opportunities to standardize and evolve audit processes.

Consumer/Patient Payment Considerations

In addition to the details of how complexity tier assignment and payment processes will function, there are important considerations related to how care coordination payments will impact patients. These considerations are consistent with the Health Care Home initiative's focus on a cultural shift toward patient- and family-centered care principles. Particularly in private insurance products, there are considerable potential challenges related to how the care coordination payments integrate with existing benefits and impose cost-sharing on consumers. Further, there are patient-focused considerations related to the patient experience and partnership with a HCH which are crucial to achieving the stated objectives of system transformation and improved outcomes. With these aspirations in mind, the following recommendations represent a strategic vision for HCH payments from the consumer/patient perspective.

Recommendations: Consumer/Patient Cost Sharing

- No consumer out-of-pocket liability (cost sharing) should be applied to reimbursement for care coordination in a Health Care Home.⁸
 - This is very important to reduce barriers to access/care and to avoid consumer confusion.
 - A wide body of research supports the phenomenon of out-of-pocket costs as a barrier to participation, and it has been observed in the Institute for Clinical Systems Improvement (ICSI)-led DIAMOND care management program⁹ as well.
 - Cost sharing would create the wrong incentives given the complexity-adjusted payment structure: those most likely to benefit from care coordination would have the highest financial barriers.

⁸ NOTE: Per existing DHS program design, there will be no co-payments or coinsurance applied to MHCP enrollees.

⁹ http://www.icsi.org/health_care_redesign_/diamond_35953/

- For commercial business, member cost sharing is a complex issue due to the varied benefit plan designs (deductibles, coinsurance, copays, and other benefit accumulators), products (self-insured plans, union-negotiated benefits, Medicare, etc.), and regulatory implications (e.g. IRS rules for High Deductible Health Plans/Health Savings Accounts). These acknowledged challenges can be addressed by better alignment of benefit structures with compatible reimbursement approaches.
- Although there are advantages to initially implementing the legislation via claims-based payment, flexible reimbursement approaches considered going forward should be structured so that health care home is part of the clinical infrastructure. This approach could address some of the complexities associated with commercial benefit designs described above, including HSA products. This approach would mitigate member cost sharing and opt-in issues. It would also HCH services to seamlessly be applied to patients as appropriate in the clinical setting, similar to the application of electronic medical records.
- For commercial insurance products, it is desirable to have a consistent consumer experience and application of benefits within an employer group for patients seeing the same provider and/or covered by the same payer.

Recommendations: Patient Information Collected to Assign a Complexity Tier

- Provider tools for complexity tier assignment that contain sensitive clinical and socioeconomic information should not be submitted routinely to payers for billing purposes. The submission of procedure code modifiers on a claim is sufficient for tier assignment for billing and reimbursement.
- Provider-payer contracts allow for chart audits as appropriate to substantiate the service level and intensity which was billed. This is similar to Evaluation and Management (E&M) code submission, which does not require submission of the detailed medical record information underlying the appropriate code definition.

Recommendations: Communication Strategies and Tools Regarding HCH Participation

- From a consumer perspective, it is preferable to have HCH “baked in” to the patient experience for the following reasons:
 - Many patients will not understand what is different with the introduction of Health Care Homes.
 - Patients will demonstrate their preferences by choosing clinics based on their HCH certification.
- Five types of information should be provided to patients and families:
 - Basic information about what a HCH is, which clinics/practitioners are certified as HCHs, and the value of HCH services to the provider and patient.

- Information about choosing a HCH, including specific HCH competencies and services.
 - Information about being an informed, activated patient and how to partner with providers. This includes mutual expectations such as making the HCH provider aware of all other health care services to facilitate care coordination.
 - Provider-developed tools to engage patients to achieve positive outcomes, including partnership agreements, orientation packets, or compacts. These should communicate what it means for a patient and the provider team to be active partners in managing the patient's condition.
 - How to be an advocate beyond the patient's own situation and become involved in the clinic's quality improvement activities.
- Key features of health care home that should be highlighted in communication to consumers include:
 - 24x7 on-call access to the HCH
 - Coordination of services between providers and care settings, and across the continuum of care
 - Shared decision making
 - Care plans as appropriate to achieve health outcomes
 - Patient relationship with practitioners and the health care team.
- MDH and/or DHS should promote newly-certified HCHs to create community-wide attention and a unified message. A special logo to designate certified HCHs may be useful to highlight these providers in the community.
- HCH materials should be developed in additional languages, preferably in audio, video, and other visual formats. It is recommended that DHS or MDH develop these multi-lingual materials and make them available to the community.

Next Steps and Continued Development

With the completion of the above recommendations, DHS will develop the dollar amounts it will pay in the fee-for-service public health care programs. Upon internal approval, the payment methodology will be submitted in the form of a Medicaid state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to gain federal authority to make the care coordination payments laid out in state law for the public programs beginning on 7/1/10.

Private payers and certified HCHs will negotiate care coordination payment rates for non-MHCP populations. These payments are also required by law to begin 7/1/10.

Tools to support tier assignment will continue to be tested and developed so that clinics can implement the process and patients are placed in complexity tiers in a consistent manner.

Stakeholders recommended that a steering committee continue to meet to provide guidance and feedback on the development, evaluation, and continued evolution of the payment methodology for Health Care Homes. In addition to informing policy and strategy, continued stakeholder input should also address more detailed implementation planning, including issues such as evaluation of the billing and audit processes, technical workflow and documentation issues, and consideration of innovative alternatives to claims-based payment for care coordination.

APPENDIX A: HCH Payment Legislation

ARTICLE 2 HEALTH CARE HOMES

Sec. 3. [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.

ARTICLE 4
HEALTH INSURANCE PURCHASING AND AFFORDABILITY REFORM

Sec. 6. [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.

APPENDIX B: Steering Committee and Work Group Membership Listings

Health Care Home Payment Methodology Steering Committee

Name	Organization	Nominated by
Jeff Schiff, MD/MBA (co-chair)	MN DHS	N/A
Nancy Jaeckels (co-chair)	ICSI	N/A
Barry Baines, MD	UCare MN	MN Council of Health Plans
Amy Burt, DO	Park Nicollet	MN Medical Association
Pat Courneya, MD	HealthPartners	MN Council of Health Plans
Mike Flicker, MBA	MDH: Rural Health & Primary Care	Lakeview Medical Clinic
Pamela Grove	Land O'Lakes, Inc.	Buyers Health Care Action Group
Jim Guyn, MD	Medica	MN Council of Health Plans
Patrick Herson, MD	BCBS MN	MN Council of Health Plans
Doug Hiza, MD	BCBS MN	MN Council of Health Plans
Dave Knutson	U of MN	N/A
Rahul Koranne, MD/MBA	HealthEast Care System	MN Hospital Association
Sharon Lahti	St. Luke's Hospital	HCH Consumer/Family Council
Marie Maes-Voreis, RN/MA	MDH	N/A
Gretchen Moen, RN/MS/CPNP	Eagan Child and Family Care	MN Nurses Association
Marilyn Peitso, MD	CentraCare Clinic	MN Chapter of the AAP
William C. Richards, MD	Park Nicollet	MN Academy of Family Physicians
John Tschida	Courage Center	HCH Consumer/Family Council
John Wheeler, MD	N/A	HCH Consumer/Family Council
Doug Wood, MD	Mayo Clinic	MN Chapter of the ACP

Work Group: Patient Complexity Tiers and Methods for MHCP Rate Development

Name	Organization
Dave Knutson (co-chair)	U of MN School of Public Health
Rahul Koranne, MD/MBA (co-chair)	HealthEast Care System
Ross Owen, MPA (staff support)	MN DHS
Jamie Carsello	UCare MN
Walt Cooney	Neighborhood Health Care Network
Michael Crandell, MD	Sanford Health Plan
Kris Kobienia	CentraCare Clinic
Kody Koepke	Park Nicollet
Kevin Larsen, MD	Hennepin County Medical Center
Jo McLaughlin	HealthPartners Medical Group
Tina Morey	Preferred One
Gary Oftedahl, MD	ICSI
Sharon Quinlan	Saint Mary's Duluth Clinic
George Schoepfoerster, MD	Physician, St. Cloud, MN
April Seifert, PhD	Medica
Missy Slater	Family Health Services MN
Mick Stokes	Lakewood Health System
Steve Thompson	BCBS MN
Carrie Tichey	HealthPartners

Work Group: Clinic and Payer Communication Processes for Care Coordination Payments

Name	Organization
Paul Berrisford (co-chair)	Family Health Services MN
Sean Burns (co-chair)	BCBS MN
Marie Maes-Voreis, RN/MA (staff support)	MDH
Brian Bergs	NorthPoint Health and Wellness Center
Justin Bonde	Hennepin Faculty Associates
Daron Gersch, MD	Albany Area Hospital and Medical Center
Gordon Harvieux, MD	Saint Mary's Duluth Clinic
Dalton Huber	New Ulm Medical Center
Amy Jo Johnson	Medica
Kathy Keenan	Park Nicollet
Patrice Kuppe	Allina
Melissa Marshall, MBA	ICSI
Julie Marquardt, DPT	MN DHS
Linda Odell-Cowles, BSN/MA	Edina Family Physicians, PA
William C. Richards, MD	Park Nicollet
Carrie Tichey	HealthPartners
Cathy VonRueden	Saint Mary's Duluth Clinic
Joanne Winter	CentraCare Clinic

Work Group: Consumer/Patient Payment Considerations

Name	Organization
Katie Sayre (co-chair)	HealthPartners
John Tschida (co-chair)	Courage Center
Carolyn Allshouse (staff support)	MDH
Sheri Alme	Target Corporation
Wendy Berghorst	Park Nicollet
Mike Flicker, MBA	Lakeview Medical Clinic
Jennifer Geisen	MN Disability Law Center
Patrick Herson, MD	BCBS MN
Janet Jorgenson-Rathke	ICSI
Ken Joslyn, MD	Medica
Deb Kersten	Allina
Mary Kurvers	Hennepin County Medical Center
Philip Stoyke	Woodbury Family Practice
John Wheeler, MD	HCH Consumer/Family Council

APPENDIX C: HCH Payment Methodology Principles

The following payment principles were discussed and broadly supported at a 4/09 public meeting, and served to guide the subsequent steering committee and work group activities:

- 1) [Non-public] payers will independently negotiate care coordination rates with health care home providers within a common framework and structure.
- 2) Care coordination payment is conditional on certification as a health care home per statute and rule.
- 3) Care coordination payment will reflect an appropriate cost to the health care home of providing the service (including an appropriate portion of the required staffing and structural elements).
- 4) In addition to care coordination payment, payers may incorporate incentives for the achievement of outcomes.
(NOTE: Improvement in outcomes related to health, patient experience, and cost as commonly agreed-upon will be required for continued certification as a health care home.)
- 5) Care coordination payment will reflect the patient's medical complexity, and will evolve toward reflecting non-medical complexity such as limited English-language skills, cultural differences, and other barriers to health care.
- 6) Providers will prospectively self-identify patients eligible for care coordination payments, and notify payers using a common multi-payer method that utilizes information on medical and non-medical complexity.
- 7) Care coordination services will be coded consistently across practices and payers, fostering uniformity in definitions of the duration of service, level of patient complexity, etc.
- 8) Stakeholders will establish a common minimum threshold of complexity for which patients are initially eligible for care coordination payment.
- 9) Gatekeeping (limiting services via primary care solely as a cost containment mechanism) is inconsistent with the health care home model. However, health care home providers will be accountable for outcomes related to health, patient experience, and cost.
- 10) The care coordination payment methodology will be collaboratively refined and will evolve over time.

APPENDIX E: Care Coordination Tasks and Functions

Summary:

At its 8/5/09 meeting, the work group reviewed and discussed key literature on the tasks carried out in performing care coordination and the amount and distribution of staff time needed. Using the available literature, a summary of the draft certification standards for health care homes in MN, and their own experience, the work group recommended that the following tasks and functions, when not currently reimbursed, be considered in the development of per-person care coordination payments to certified health care homes.

Task/Function List:

(Items marked with a “★” were identified as likely to require considerably more time and resources for more complex patients.)

- ★ Telephone and e-communication
 - with patients
 - with caregivers
- Visit time not currently reimbursable (scheduling blocks to meet access requirements for health care home certification)
- Establishing patient/family partnerships, recruitment/outreach, education (including enrollment and ongoing engagement) as required for health care home certification
- Travel for care that must take place outside of the usual clinic location, e.g. house calls for home bound frail elderly
- Registry and panel management
 - “triggers” for care
 - provider decision support
- Patient-centered care: tools, resources and time necessary to ensure that decision-making and care are consistent with patients’ culture, values, and preferences
- Coverage and insurance coordination, including time spent filling out forms and documents required for coverage.
- Pre-visit planning
- Family conferences
- ★ Care team conferences

- ★ Transition planning and management
- ★ Medication reconciliation
- Behavior change coaching
- ★ Care planning
 - integration of specialty care
 - coordination with community resources
- Initial and periodic risk screening
- Measurement, analysis and submission of quality indicators as required for health care home certification
- Learning collaborative participation as required for health care home certification

General Considerations:

The work group recommended that the following overarching issues be taken into consideration in the development of care coordination rates.

- 1) *Fixed Costs.* The work group recognized there are two main categories of fixed costs related to operating a health care home: start-up costs and maintenance fixed costs. Examples of these include the time and resources to develop a patient registry, and the ongoing costs of keeping the software current and maintaining the tools. The work group recommended that specific strategies be developed to address these fixed costs and that they be considered in the development of the care coordination rates.
- 2) *Overlap with Currently Reimbursed Services.* The work group recognized that the task/function list above contains a number of items that may already be separately coded and reimbursed in current fee-for-service arrangements. The work group recommended that the care coordination rates reflect only those services listed above that are not reimbursed separately elsewhere.

APPENDIX F: Draft Tier Assignment Tool

Care Coordination Tier Assignment Tool Health Care Home Initiative

A. DEFINITIONS:

Severe Conditions¹ are defined as major and potentially unstable conditions that, without optimal care, are likely to worsen and lead to altered physiologic state, impairment, or death.

Chronic Conditions² are those that have lasted at least six months, can reasonably be expected to continue for at least six months, or are likely to recur.

Requires a Care Team³ means that multiple members of a care team (such as primary care provider and a specialist, or a care coordinator and a social worker) are required for this condition to attain or maintain stability and optimal health status for the patient. This includes preventive care or coordination to prevent progression of disease, deterioration, or gaps in care.

Care Team means a group of health care professionals who plan and deliver patient care in a coordinated way through a health care home in collaboration with a participant. The care team includes at least a personal clinician and the care coordinator and may include other health professionals based on the participant's needs.

B. SCORING FORM TO DERIVE CARE COORDINATION TIER

SCORE⁴ counts as 1 for each condition if *all three* severe, persistent, care team boxes are checked. Otherwise, **SCORE** is 0. Provide a score for each line of the form (either a 1 or a 0).

SUM COUNT⁵ is the sum of scores from all lines.

C. DERIVING TIERS⁶

This is a simple conversion of SUM COUNT using the table shown below:

SUM COUNT	TIER	(For example, a SUM COUNT of 5 is TIER 2)
0	0	
1-3	1	
4-6	2	
7-9	3	
10 or more	4	

D. SUPPLEMENTAL FACTORS

Must use a non-English primary language to communicate about their health care⁷ means that English skill levels are not sufficient to discuss and create complicated care plans, complex care choices and options, etc. This includes the deaf and hearing-impaired.

Serious and Persistent Mental Illness⁸ for this screening tool means a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder. This may apply to the patient, or to a caregiver of a dependent patient. Checking this box infers that some level of functional impairment is observed. This definition was derived from *Minnesota Statute 245.462, subdivision 20*.

If the primary language or mental health boxes are checked, they will be used to modify the basic Tier structure to account for the increased care coordination efforts these situations represent.

Care Coordination Tier Assignment Tool Health Care Home Initiative

Patient ID: _____

Date: ____/____/____
month / day / year

Does this patient present with these conditions.....	Condition Is Severe ¹	Condition Is Chronic ²	Condition Requires A Care Team ³	SCORE ⁴
<input type="checkbox"/> Allergy, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gastrointestinal/Hepatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Health/Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rheumatologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Female Reproductive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Genetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Toxic Effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ear, nose, and throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check either of the boxes below if they apply

(These factors are not added to the sum count):

- The patient or caregiver of a dependent patient must use a non-English primary language to communicate about their health care⁷.

- The patient or caregiver of a dependent patient has a serious and persistent mental illness⁸.

SUM COUNT⁵ TIER⁶

Derive patient Tier assignments using the table shown below:	
SUM COUNT	TIER
0	0
1-3	1
4-6	2
7-9	3
10 or more	4