Health Care Homes (HCH) and Integrated Health Partnerships (IHP):

With the implementation of Integrated Health Partnerships (IHP) 2.0, questions have come forth from organizations about how Health Care Homes aligns and intersects with IHP 2.0. This brief overview introduces both programs and describes how HCH certification is fundamentally structured to support value based care arrangements (such as IHPs).

Health Care Homes (HCH)

The HCH program is one of the centerpieces of Minnesota's multi-agency effort to improve the delivery of primary care. Minnesota's model embraces the principles of a Patient-Centered Medical Home, the more common national term, choosing the name "Health Care Home" to acknowledge a shift from a purely medical model of health care to a focus on linking primary care to wellness, prevention, self-management and community services. Coordination of care is a hallmark of health care homes.

Integrated Health Partnerships (IHP)

Integrated Health Partnerships is Minnesota's implementation of an Accountable Care Organization (ACO) model in its Medical Assistance (Medicaid) program. The goal of the IHP program is to improve the quality and value of the care provided to the citizens served by public health care programs. Participating providers enter into an arrangement with the Department of Human Services (DHS), by which they are accountable for the total cost and quality of care for the attributed population.

HCH and IHP Intersection

The goals of the HCH and IHP framework are similar:

- Improve health outcomes (preventative, routine, treatment of health conditions) of individuals.
- Improve experience of care for the individual.
- Improve the quality of life and wellness of the individual.
- Reduce health care costs.

Both HCHs and IHPs are held to standards for access to care, population health management and registry tracking, coordination of care, quality improvement, and performance measurement. Applicant IHPs may use HCH certification as required evidence for the provision of coordinated care. For applicant IHPs who are not certified/recognized as Health Care Homes, DHS requires a description of how expected characteristics are present in their care model.

Overview of HCHs and IHPs		
Program Attribute	**Health Care Home**	**Integrated Health Partnership 2.0**
Participating providers	Primary care entities that offer the full spectrum of primary care (acute, chronic, preventative)	All entities must be able to offer or have a partner entity able to offer a full scope of health care services.
Population	Whole primary care population	Attributed Medicaid population
Care Delivery Model	Patient/family centered care principles embedded in the following certification standards: • Communication & Access • Patient Tracking & Registry Use • Care Coordination • Care Planning • Quality Improvement based on the IHI's Triple Aim	• Enhanced access to care • Health IT capability and Population Health Management strategies • Care coordination • Population Health & Health Disparities • Community Partnerships & Social Determinants of Health • Quality Measurement
Performance Measurement	Participation in Statewide Quality Reporting and Measurement System (SQRMS); performance measurement through HCH Benchmarking.	Annual performance standards selected from the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) set of measures, the Adult and Child Medicaid Core Sets of Measures, the Healthcare Effectiveness Data and Information Set (HEDIS), as well as the Medicaid Electronic Health Records (EHR) Incentive Program.
Learning & Technical Assistance	Learning opportunities within the HCH Learning Collaborative include: Learning Days, webinars, online resources, HCH newsletter: *The Connection*, and others. Regional nurse planner support available for technical assistance.	Quarterly Data Users Group Meetings with DHS Annual IHP Learning Day

A note about duplicative payments: IHP 2.0 offers a quarterly population based payment (PBP) based on a specific methodology to support the care coordination and other activities of a value based arrangement. This PBP would take the place of any current HCH care coordination payments so as not to duplicate billing, but this would be only for those within that IHP attributed population.

Alternative Payment Models and Financial Sustainability

Overall, payment models are becoming increasingly value based. Having a foundational infrastructure that provides accessible, effective, team-based integrated care within a health care system is essential to successful participation in these models. This should include assurances that care is delivered in a culturally competent and patient/family centered manner.

- The Joint Principles of ACOs states that primary care should be the foundation of any ACO and that the recognized patient and/or family-centered medical home (i.e. HCHs in Minnesota) is the model that all ACOs should adopt for building their primary care base. https://www.acponline.org/acp_policy/policies/joint_principles_accountable_care_organizations_2010.pdf
- Patient-Centered Primary Care Collaborative (PCPCC) statement on how medical homes relate to ACOs: "ACOs require a strong primary care strategy in order to sustain their goals for population health improvement and lower total cost of care. As payment for primary care practices is fundamentally restructured to support value-based care, advanced primary care and medical homes must be recognized as foundational to ACOs and other integrated delivery reforms." https://www.pcpcc.org/sites/default/files/page-files/What-is-a-PCMH-FAQ_0.pdf

For Further Information and Questions

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If you have questions regarding Integrated Health Partnerships, please contact: Mat Spaan, mathew.spaan@state.mn.us