Health Care Homes and Accountable Care Organizations

Testimony to the Health and Human Services Finance Committee of the Minnesota House of Representative

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Delivery and Payment Reform in Minnesota – Health Care Home to Accountable Care

- 2003 –HRSA grant to provide medical home for children with special health care needs
- 2006 Minnesota Legislature funding for the state's medical home learning collaborative
- 2007- first Minnesota legislation to pay for care coordination
- 2008- major Minnesota health care reform legislation including Health Care Home
- 2010 – Demonstrations authorized for accountable care- risk/gain sharing and safety net hospital demonstrations

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Federal reform efforts

- Multipayer Advanced Primary Care – Medicare joining state multipayer medical home projects in progress
- Increase in federal match (to 90%) for two years for medical home payments
- Medical home for Federally Qualified Health Care Centers
- Center for Medicare and Medicaid Innovation
- Medicare Shared Savings program
- Pediatric Accountable Care Organization (ACO)
- Medicaid Safety Net hospital capitated ACO

Foundational Elements of Delivery Reform – Why Primary Care?

"That a power imbalance exists between doctors and patients has been readily acknowledged…. However the effects of this asymmetry can be mitigated through the establishment of trust between doctor and patient"

- Loree K Kallianinen,MD

- Patient and Family Centered Care
- "Agency/ Advocate" role of providers
- Advocate vs. steward of resources
- Creating and regulating the right market in health care

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Primary Care Orientation

- In the US, the number of primary care physicians per population was the only characteristic consistently related to better outcomes, including overall mortality rates, mortality rates from heart disease and cancer, neonatal mortality, life span, and low birth weight.[i]
- In contrast, the number of specialty physicians per population was related to worse [or no change in] outcomes in all these areas

[i]Shi L. Primary care, specialty care, and life chances. *Int J Health Serv.*1994; 24 :431 –458

Evidence for Health Care Home

- There is now even stronger evidence that investments in primary care can bend the cost curve, with several major evaluations showing that patient centered medical home initiatives have produced a net savings in total health care expenditures for the patients served by these initiatives.
    - Grumbach and Grundy 2010
    - Outcomes of Implementing PCMH Interventions
    - http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

Primary Care Orientation
What is Primary Care?

- accessibility for first-contact care for each new problem or health need,
- long-term person-focused care ("longitudinality"),
- comprehensiveness of care in the sense that care is provided for all health needs except those that are too uncommon for the primary care practitioner to maintain competence in dealing with them, and
- coordination of care in instances in which patients do have to go elsewhere. I]

[i] B Starfield and L Shi. The Medical Home, Access to Care, and Insurance: A Review of Evidence." *Pediatrics* 113(5):1493-1498.

What is a medical home?

- Primary care based care coordination
- Partnership with patients and families
- Linkages to community resources
- Continuous improvement process
- Improved office systems to
  - Track and monitor progress
  - Evaluate outcomes

Health Care Home

Also known nationally as the

- Patient Centered Medical Home (PCMH) or

Federally as

- Advanced Primary Care (APC)
- Health Home

Minnesota Health Care Home Program

2008 Enabling legislation

- Designation criteria in state rule
- Active clinic certification process
- Learning collaborative
- Complexity adjusted payment methodology
- Outcomes reporting and results required for recertification

Statewide approach, public / private partnership

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Health Care Home Certification

- Standards developed by community / science based.
- The health care home rule was adopted and published on January 11, 2010.
- Certification is voluntary.
- Primary care providers / clinics are certified.
- There is ***flexibility for innovation*** built into the certification process.

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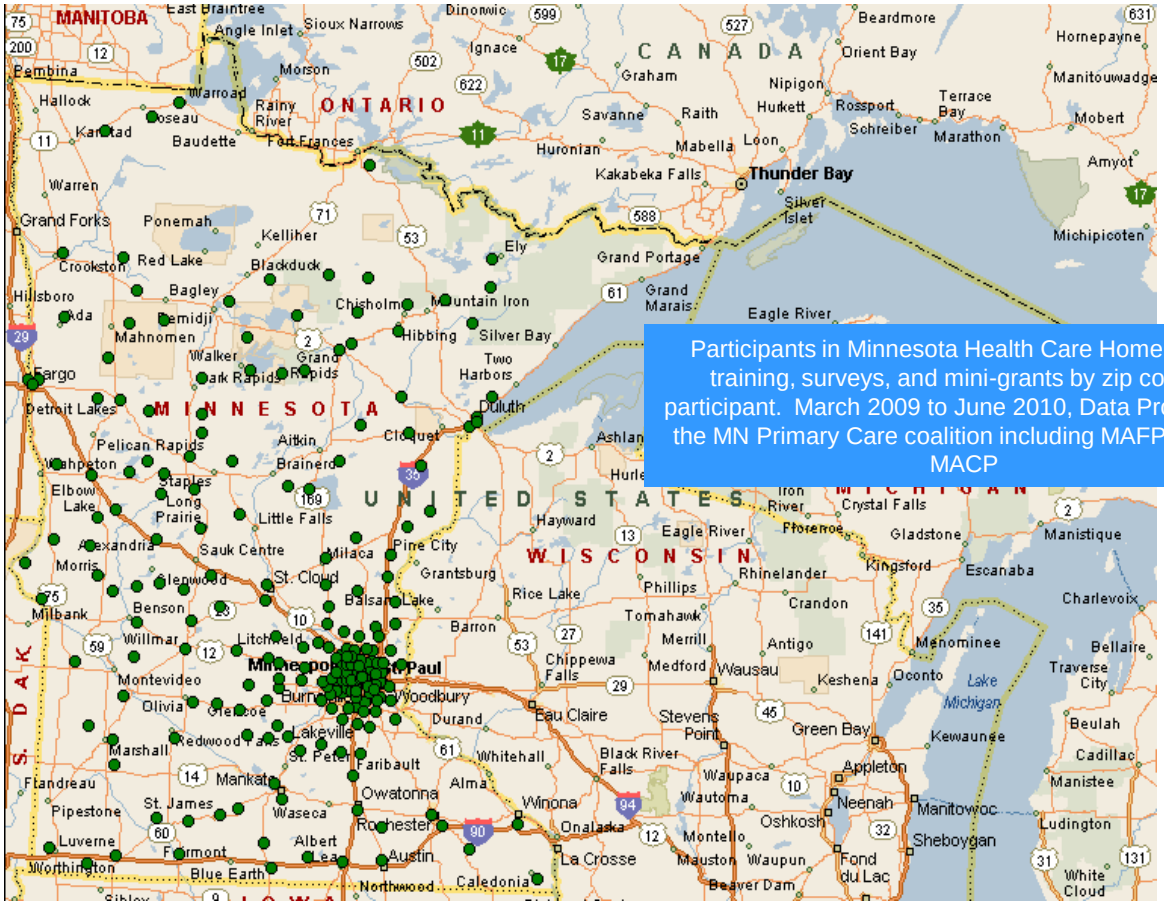
Health Care Home Standards

- **Access: facilitates** consistent **communication** among the HCH and the patient and family, and provides the patient with **continuous access** to the patient's HCH
- **Registry: uses** an electronic, searchable **registry** that enables the HCH to identify gaps in patient care and manage health care services
- **Care coordination: ** coordination of services that focuses on **patient and family-centered care**
- **Care plan:** for selected patients with a **chronic or complex** condition, that involves the patient and the patient's family in care planning
- **Continuous improvement: ** in the **quality** of the patient's experience, health **outcomes**, cost-effectiveness of services

Statewide Participation in Certification Planning



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Certification Updates

 # Certified: Clinics: 47

 # Certified Providers: 413

Patients Participating in certified clinics: 1,166,657

Clinics final stages: 93

Providers: 1,098

Clinics early process: 15

Providers: 210

Many others in the planning / transformation stages

- Applicants are from all over the State
- Variety of practice types such as solo, rural, urban, independent, community, FQHC and large organizations.
- All types of primary care providers are certified, family medicine, peds, internal med, med/peds and geriatrics.

Learning collaborative activities underway!

- Regional workshops through out State
- Monthly webinars continue
- Payment methodology train the trainer
- ICSI is Learning Collaborative Vendor: 2/2/11
  - –Goal 1,300 participants in learning collaborative
  - –Curriculum development peds / adults
  - –Establish Learning Collaborative Leadership Committee
  - –Regional (in person and virtual learning)
    - **Phase I - Preparation (pre-certification).** Voluntary for clinics / clinicians that intend to become certified as a HCH
    - **Phase II – Certification / Implementation:** Required for all HCH certified clinics/clinicians.
    - **Phase III - Ongoing improvement and maintenance.** Required for all certified HCH's after they complete Phase II.

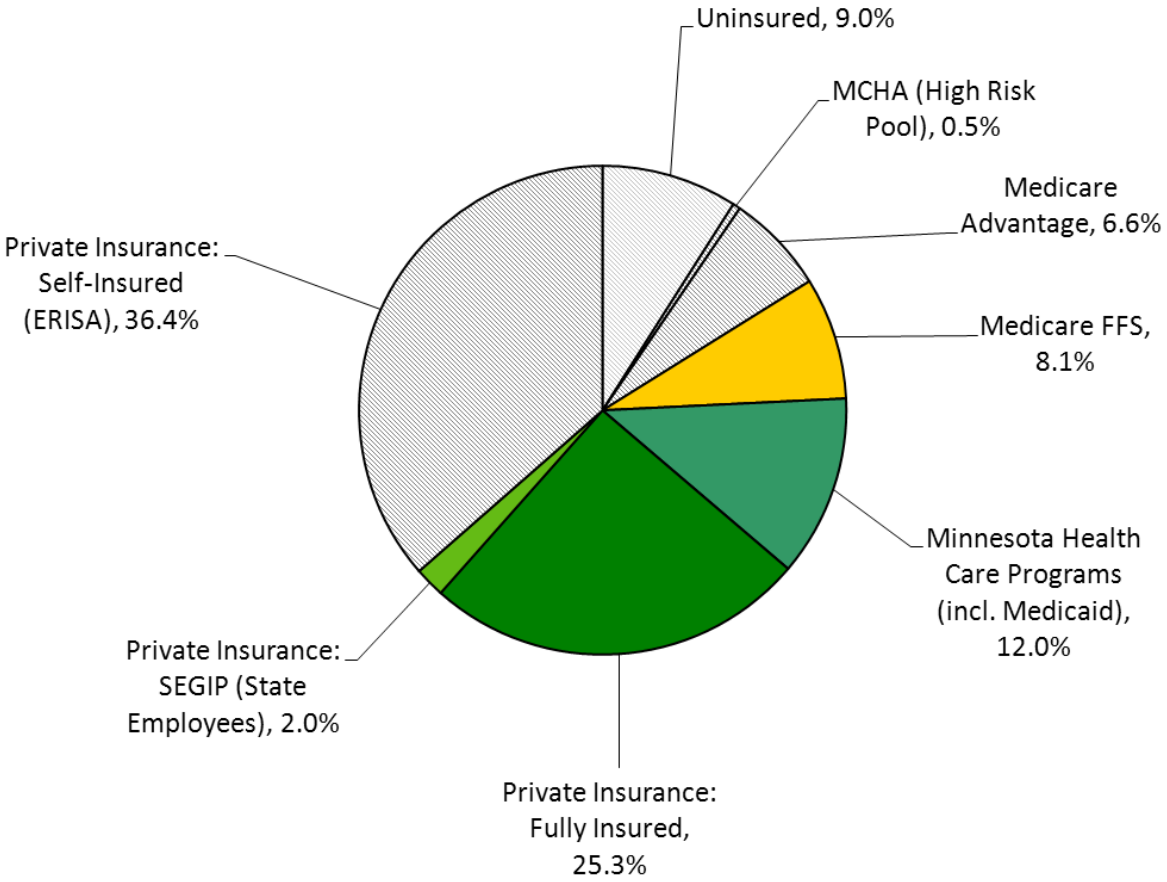
HCH Payment Methodology

- Per-member per-month payments representing the value-creating work of care coordination that hasn't historically been reimbursed
- Payments required to be budget neutral: (mostly expected through fewer avoidable hospital admissions and ED visits)
- In the MN public programs, rates = 2-4% of total spending for qualifying enrollees

HCH Payment Methodology

- Higher payment for more complex patients – providers assess patient complexity using an agreed-upon structure and bill for the service
- Multi-payer participation
- Addition of Medicare through the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration

MN's Population by Insurance Status: HCH and the "Critical Mass" Challenge



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

Health Care Home Evaluation

- Based on IHI “Triple Aim”, population health, patient experience, affordability of care by decreasing per capita costs
- Recertification annually, outcomes measures based on benchmarks.
- Research transformative elements of HCH, AHRQ grant, TransforMN partner HP Research Foundation.
- Contract for overall effectiveness of HCH
- Legislative reporting requirements, 2013

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Accountable Care Organization

"A set of providers [which are held] responsible for the health care of a population of Medicare beneficiaries."

-MedPAC (Medicare Payment Advisory Commission)

"An entity that can implement organized processes for improving the quality and controlling the costs of care and be help accountable for the results."

-Stephen Shortell and Lawrence Casilino

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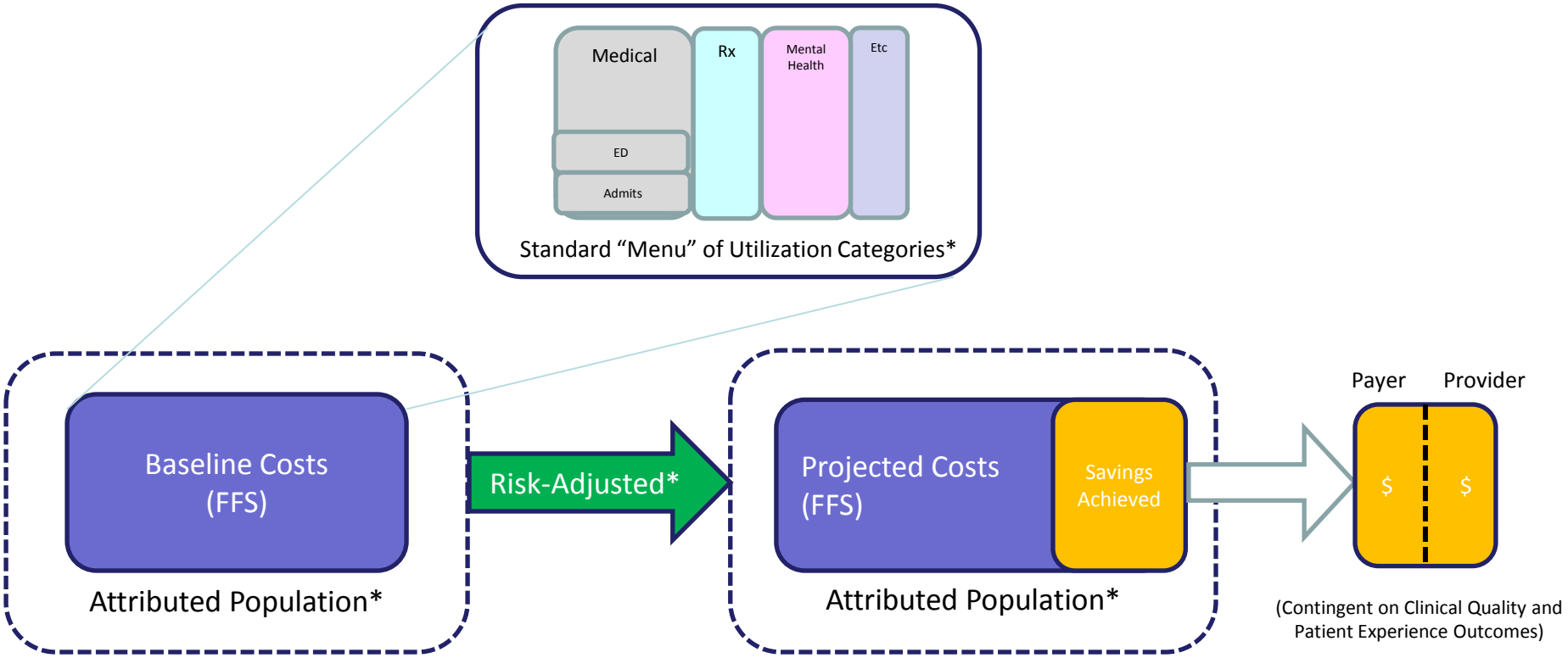
From Health Care Homes to Accountable Care Organizations

- Health Care Homes are the base for development of Accountable Care Organizations
- What in our Health Care Home model sets us up to move to accountable care?
  - Robust primary care transformation
  - Risk stratified payments
  - Measurement for recertification
    - Patient experience
    - Quality of care
    - Cost and utilization

Accountable Care Organizations as the next step

- Balance and place “risk” at the right place in the system
- Balance incentives to the providers to insure appropriate care, then decreasing inappropriate utilization
  - Requires feedback systems
- Common methodologies essential for provider level critical mass
- Incremental development

Shared Savings Model (Overview)



* High opportunity for multi-payer alignment

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Accountable Care Organization Components

- Attribution of patients to providers/ organizations
- Risk adjustment/ derivation of predicted total costs
- Payment options – risk/ gain sharing – based on
  - Complexity of the population
  - Size of the population
  - Degree of integration across the care spectrum

Accountable Care Organization Components (continued)

- Payment contingent on outcomes for quality and patient experience
- Payment must address the needs of the very complex

Challenges
(besides building all of the above)

- Federal authority
  - Patient protection of choice
  - Access to services
  - Appropriate provider incentives
  - Appropriate protection of providers from anti trust/ kick back statutes
- Provider level critical volume of patients
- Adequate measures of quality

Supplemental information

- Web sites MDH/ DHS
  - www.health.state.mn.us/healthreform/homes/index.html
  - www.dhs.state.mn.us/healthcarehomes
- Statutes 2008 and 2010
- Accountable Care Organizations
  - www.chqpr.org
- Commonwealth Fund
  - www.commonwealthfund.org/

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