WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 3

TO: MEMBERS OF THE SPECIAL COMMITTEE ON PERFORMANCE-BASED DISEASE MANAGEMENT PROGRAMS FOR LARGE POPULATIONS

FROM: Mary Matthias, Senior Staff Attorney

RE: 2008 Minnesota Legislation on Health Care Homes

DATE: October 9, 2008

This Memo, prepared at the request of Chairperson Wieckert, provides information on recent Minnesota legislation pertaining to health care homes. This legislation was discussed by Laura Tobler of the National Conference of State Legislatures at the September 12, 2008, meeting of the Special Committee, and several speakers recommended that the Special Committee consider establishment of health care homes (also referred to as "medical homes") in Wisconsin.

In March 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released a consensus statement describing the medical home model of care delivery. The document, titled "Joint Principles of the Patient-Centered Medical Home" is included as an attachment to this Memo.

Minnesota's 2008 Health Care Reform Act (the Act) was signed into law in May, 2008. (Minnesota Laws 2008, Chapter 358.) The Act contains provisions pertaining to a number of different health care reform topics. Article 2 of the Act (s. 256B.0751, et seq. Minn. Stat.), described below, created statutory requirements for the certification and utilization of health care homes.

The Act applies primarily to "state health care programs," defined as medical assistance, MinnesotaCare, and general assistance medical care programs. (MinnesotaCare is a jointly funded, federal-state program administered by the Minnesota Department of Human Services that provides subsidized health coverage to eligible Minnesotans.) These provisions are described in Part A of the Memo. Provisions of the Act that apply to private insurance carriers and the state employees group insurance program are described under parts B and C, below.

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A. STATE HEALTH CARE PROGRAMS

Certification Standards for Health Care Homes

The Act requires the commissioners of the state health and human services departments (the state commissioners) to develop and implement standards of certification for health care homes for state health care programs by July 1, 2009. The state commissioners must consider existing standards developed by national independent accrediting and medical home organizations.

The standards developed by the commissioners must do all of the following:

- Emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;
- Focus on delivering high-quality, efficient, and effective health care services;
- Encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;
- Provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;
- Ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;
- Enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;
- Focus initially on patients who have or are at risk of developing chronic health conditions;
- Incorporate measures of quality, resource use, cost of care, and patient experience;
- Ensure the use of health information technology and systematic follow-up, including the use of patient registries; and
- Encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

Requirements for Clinicians and Clinics Certified as Health Care Homes

Under the Act, a personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. Certification as a health care home is voluntary.

In order to maintain its status as a health care home, a clinician or a clinic must renew its certification annually.

Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

Health care homes must participate in the health care home collaborative that the state commissioners must establish by July 1, 2009. The collaborative must be designed to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Evaluation of Health Care Homes

To maintain certification, a health care home must meet process, outcome, and quality standards developed by the state commissioners. The commissioners must collect data from health care homes that is necessary to monitor compliance with certification standards and to evaluate the impact of health care homes on health care quality, cost, and outcomes. The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes.

Outreach

Beginning July 1, 2009, the state commissioners must encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Payment Restructuring and Care Coordination Payments

By January 1, 2010, the state commissioners must develop a payment system that provides per-person care coordination payments to certified health care homes for providing care coordination services and directly managing or employing care coordinators. Care coordination fees may be phased in if fees are applied first to individuals who have, or are at risk of developing, complex or chronic health conditions.

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 commissioners must 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. 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 must require the payment of care coordination fees to certified health care homes.

Cost Neutrality

The Act specifies that 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.

B. PRIVATE HEALTH PLAN COMPANIES

The Act requires health plan companies to include health care homes in their provider networks by January 1, 2010.

Health plan companies must pay a care coordination fee for their members who choose to enroll in certified health care homes by July 1, 2010.

Health plan companies must 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 by the state commissioners for state health care programs.

The Act authorizes health plan companies to continue 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.

Under the Act, "health plan companies" include both of the following:

- "Health carrier" which means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

- "Community integrated service network" or "community network," which means a formal arrangement licensed by the commissioner under section 62N.25 for providing prepaid health services to enrolled populations of 50,000 or fewer enrollees, including enrollees who are residents of other states.

C. STATE EMPLOYEE GROUP INSURANCE PROGRAM

By July 1, 2010, the state commissioner of finance must implement 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.

MM:ksm

Enclosure