

Health Care Homes:

Minnesota Health Care Programs (MHCP) Fee-for-Service Care Coordination Rate Methodology



Health Care Homes | HCH



Minnesota Department of **Human Services**

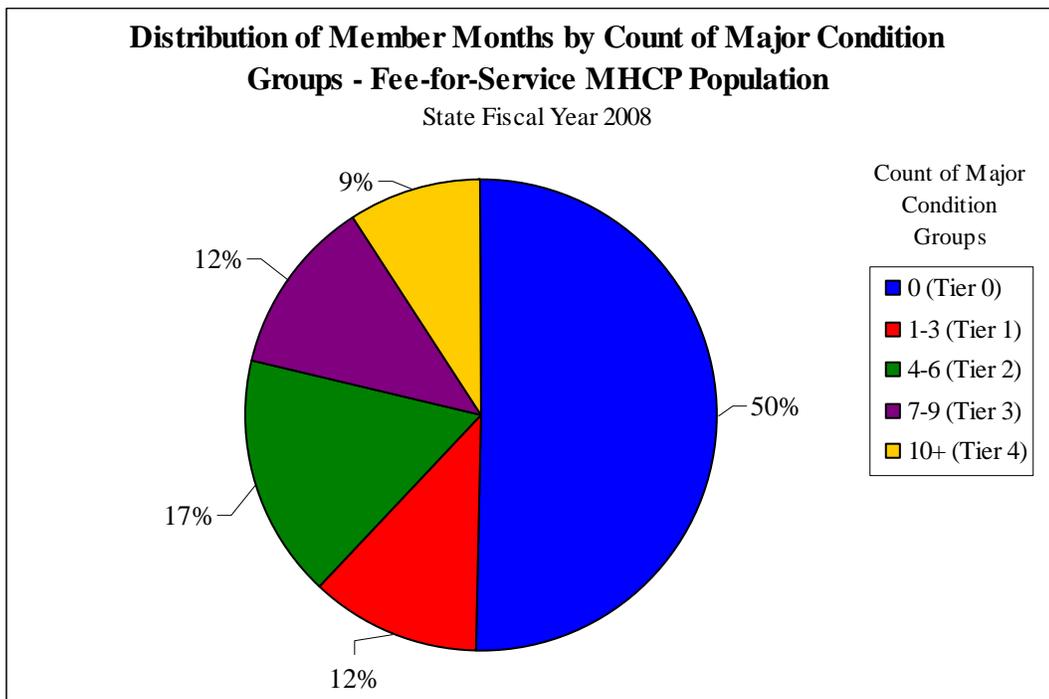
Introduction and Background

Minnesota's 2008 Health Reform legislation calls for the creation of a certification process for Health Care Homes (HCH), as well as a system of per-person risk-stratified care coordination payments to certified Health Care Homes. These payments must be made for all Minnesota Health Care Program (MHCP) enrollees, state employees, and state-regulated private health plan products. The payment methodology, including a system of categorizing patient complexity, clinic and payer payment processes, and consumer/patient recommendations, was designed with extensive stakeholder input throughout 2009.

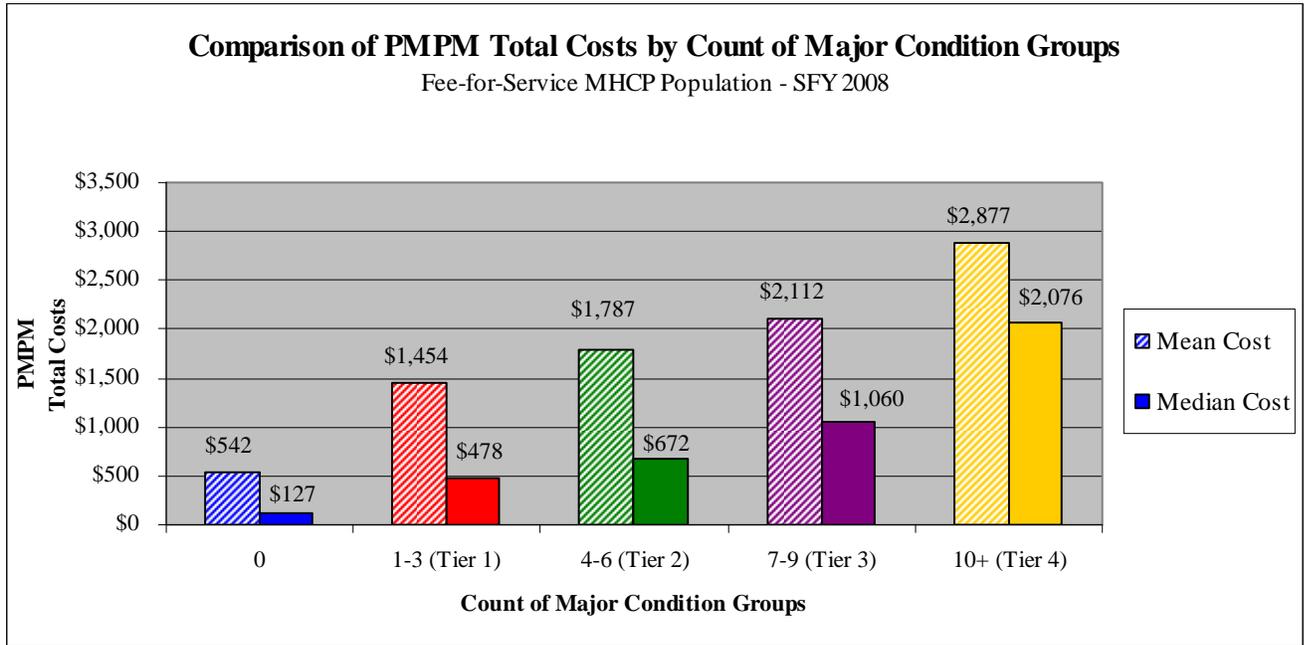
In order to implement the care coordination payments in MHCP, the Department of Human Services considered the overall design of the Health Care Home payment methodology and developed dollar amounts for the care coordination payments in the fee-for-service public programs. The information that follows lays out the rationale for the development of these rates. *These dollar amounts are subject to approval by the Centers for Medicare and Medicaid Services (CMS) through the Medicaid State Plan Amendment process, and represent only what will be proposed to CMS. All care coordination rates outside of MHCP will be negotiated privately.*

Complexity Tiers

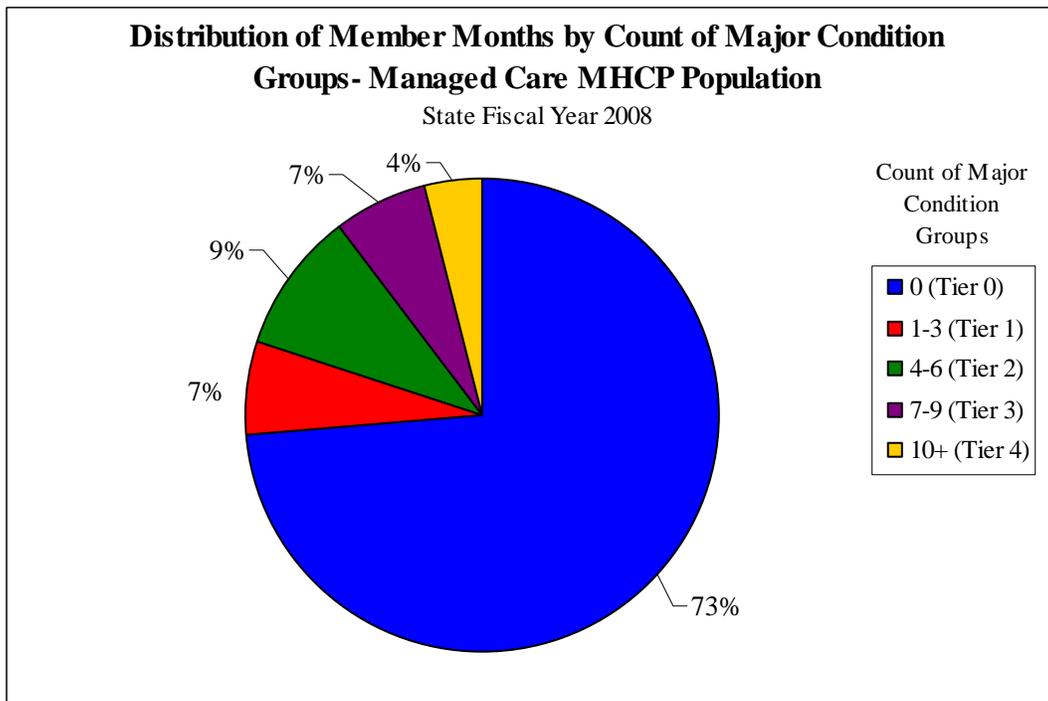
The payment rates are based on a complexity tiering structure in which providers will identify and count the number of "major" conditions (conditions that are chronic, severe, and likely to require a care team). Based on claims data, DHS has modeled the following distribution in MHCP fee-for-service:



Total cost values for each tier in fee-for-service are displayed below. These figures represent actual medical, long-term care, and waived service expenditures.



For comparative purposes, the same distribution was modeled for the MHCP managed care population to illustrate how the tiering system looks in a population with a lower disease burden.



Care Coordination Time Assumptions and Rates

The count of major conditions serves as a proxy for the time and work required to coordinate patient care in the HCH. In order to arrive at rates, we must start with a reimbursement value for a time unit of care coordination and then make assumptions about the amount of care coordination time and work per member per month (PMPM) for each tier. These assumptions were informed by a survey of the best available literature on care coordination.

DHS began with the current reimbursement for a 40-60 minute evaluation and management (E&M) visit (CPT code 99215 = \$65.92)¹ as the base value for one hour of physician work. Because the work of care coordination in a HCH is divided between the physician and other members of the care team, DHS assumed the following distribution of work in an optimally-functioning practice:

- 20% Physician
- 50% Care Coordinator
- 30% Office/Clerical

After discounting for this work distribution over time (care coordinator time at 65% of the physician rate and office/clerical time at 30%), the MHCP fee-for-service rate for one hour of care coordination in a HCH is \$40.54.

DHS proposes paying a PMPM care coordination rate for patients in Tiers 1-4: the roughly 50% of the fee-for-service population with one or more major chronic conditions) based on the following literature-supported assumptions regarding the work of care coordination:

Tier	Minutes of Work PMPM	PMPM Rate
0	N/A	N/A
1	15	\$ 10.14
2	30	\$ 20.27
3	60	\$ 40.54
4	90	\$ 60.81

The adjusted average PMPM rate for Tiers 1-4 is **\$31.39**.

There will also be a 15% increase in the rate for each tier for patients that have:

- A primary language other than English
- A serious and persistent mental illness

(For instance, a Tier 1 patient who also has a serious and persistent mental illness would have a rate of \$11.66, and a Tier 1 patient with both a serious and persistent mental illness and a primary language other than English would have a rate of \$13.18.) Based on DHS claims data, these “supplemental” complexity factors will increase the care coordination payments across the fee-for-service population by 3.8% (compared to just the PMPM payments based on diagnosis).

¹ Note – The 2010 total Medicare RVU values for 99215 are as follows: Nonfacility National = 3.68; Nonfacility Locality (MN) = 3.5552; Facility National = 2.92; Facility Locality (MN) = 2.8082.

Works Consulted

AMA/Specialty Society RVS Update Committee Medicare Medical Home Demonstration Project (AMA). RUC Recommendations for the Medicare Medical Home Demonstration Project. American Medical Association, April 25, 2008. Downloaded on March 13, 2009 from www.ama-assn.org/ama1/pub/upload/mm/380/medicalhomerecommend.pdf.

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