

Hennepin Health

June 2014



Hennepin Health is an innovative, integrated, health care delivery program for adults in Hennepin County, Minnesota. The program takes a holistic view, focusing on each member's medical, mental health, and social needs. Services include housing and social services navigation, employment counseling, targeted case management, and access to clinics designed to meet members' complex needs. Hennepin Health is proving that health care reforms can improve clinical outcomes and patient satisfaction, and decrease unnecessary costs.



Hennepin County

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Hennepin Health structure and basics

This health reform demonstration project is conducted in collaboration by Hennepin County and the Minnesota Department of Human Services, Minnesota's Medicaid agency. The program, launched in 2012, is a partnership between the following Hennepin County entities:

Hennepin County Human Services and Public Health Department, the county's social services agency, public health department, and home to a number of clinical providers including health care for the homeless and the county's mental health center

Hennepin County Medical Center, an urban safety net health system, including a hospital, primary care and specialty clinics

Metropolitan Health Plan, a county-operated not-for-profit health maintenance organization

NorthPoint Health & Wellness Center, a county-operated community clinic located in north Minneapolis

Together, these entities are the core components of an accountable care organization. Hennepin Health partners contract jointly (via Metropolitan Health Plan doing business as Hennepin Health) with the Minnesota Department of Human Services to provide full Medicaid benefits to enrollees through a capitated (fixed total cost of care) payment arrangement. From a regulatory and enrollment perspective, Hennepin Health is a managed care option for a high-risk population of qualifying Medicaid expansion enrollees who live in Hennepin County. Within that managed care structure, Hennepin Health is a defined network of health care and social service providers who are uniquely positioned to better coordinate and integrate care. A voluntary risk-sharing arrangement among partners provides powerful incentives to improve health outcomes and reduce the cost of care.

Hennepin Health has supplemented its defined partner network in two key areas. The network of primary care clinics includes a small number of additional providers to ensure access to care in identified geographic and cultural areas. The plan's behavioral health network is open access, because barriers to access in mental and chemical health services reach across our community.

Medicaid recipients are prospectively enrolled in Hennepin Health through the existing managed care selection process in Hennepin County. People who meet eligibility criteria, including residence in Hennepin County, are offered Hennepin Health as a health plan choice alongside other, more traditional Medicaid managed care options. Qualified people who do not make an active health plan choice within the allowed timeframe are enrolled in Hennepin Health as the default option if they reside within a defined set of zip codes.

Hennepin Health had enrolled about 8,600 members as of May 2014.

The care model and concept plan for Hennepin Health emerged in 2010 from an organizational crisis. Minnesota's General Assistance Medical Care program, which provided state-funded medical coverage for low-income adults without dependents, was eliminated. It was replaced with a voluntary, hospital-based block grant program that dramatically reduced available funding.

As participants, Hennepin County Medical Center was forced to quickly shift focus to build systems to meet the needs of the population, and to mitigate potentially crippling financial losses. They chose to focus on aggressively managing care on an outpatient basis, rather than waiting for patients to access care in inpatient settings or through the hospital's Emergency Department. In 2011, when Minnesota opted to extend Medicaid coverage to this population, Hennepin County was better-positioned and more willing to be accountable for this group on a full-risk basis, now under a more sustainable funding structure.

There now is considerable national interest in the Hennepin Health model as the Medicaid expansion reaches other states. The work in Hennepin County has revealed some of the ways in which the health delivery system must adapt to deliver high-value care to this medically and socially complex population.

The Hennepin Health population

Hennepin Health serves a unique and complex subset of Medicaid enrollees: Minnesota's Medicaid expansion population. The population is composed entirely of adults ages 21-64, who do not have disabilities, and who do not live with dependent children. From the January 2012 launch of Hennepin Health through the end of 2013, the program's clientele was limited to Minnesota's optional early Medicaid expansion population, who earned no more than 75 percent of the federal poverty level. With the further expansion of Medicaid eligibility allowed by the Affordable Care Act in 2014, Hennepin Health now serves people who earn up to 138 percent of the federal poverty level.

Hennepin Health members represent roughly one quarter of the Medicaid expansion population in Hennepin County. They are

- 75 percent male
- 69 percent racial/ethnic minority
 - 58 percent black (non-Hispanic)
 - 6 percent American Indian/Alaskan
 - 3 percent Hispanic
 - 2 percent Asian
- 42 percent have a mental health condition
- 45 percent have a chemical dependency issue
- 30 percent have one or more chronic physical condition
- An estimated 32 percent have unstable housing

The population is also characterized by an identified lack of social support and scant history of health insurance. As a group, they are heavy users of expensive acute care services and are overrepresented among the 5 percent of Medicaid beneficiaries who drive more than 50 percent of spending nation-wide.

Premise and overarching goals

Hennepin Health is based on the recognition that most of what drives health care utilization and influences health outcomes happens outside of the traditional health care delivery system. It is built on the premise that only through building relationships and addressing the basic needs of individuals (the social determinants) can we meaningfully improve health.

Hennepin Health creates a link between physical and mental health, inpatient and outpatient care, and social services. That connection is a powerful force for change in the care provided to safety net populations.

By better coordinating care and addressing the social factors that affect health, Hennepin Health aims to:

- Improve members' health care experience and quality of life
- Improve quality of care and experience of providers and staff
- Reduce costs to the county, state and federal governments, allowing for innovative health-related reinvestments
- Reduce health and social disparities
- Build a model that is sustainable and can be replicated throughout the state and in other parts of the country

Care model

Hennepin Health care model

Hennepin Health's care model is anchored by outpatient clinics operated by Hennepin County Medical Center and NorthPoint, which function as patient-centered medical homes. In Minnesota, this means that the state Department of Health has certified the clinics as health care homes, and that the clinics have demonstrated competence in the areas of patient data, care coordination, care planning quality improvement and access and communication. These clinics offer a baseline level of care coordination across the system. Multidisciplinary teams include:

- Clinical care coordinators (registered nurses)
- Community health workers
- Social workers

All Hennepin Health members are assigned to primary care clinics that are responsible to coordinate their care, but they are free to seek care within the Hennepin Health network as they choose. The clinic assignment is done through an algorithm that identifies a clinic based on the member's address and health care history. The most medically and socially complex members also are assigned a "call me first" individual, who can be any of the roles above based on the individual's needs. Once they have established a relationship with a primary care clinic team, members complete a lifestyle overview to comprehensively assess their health risk factors and social needs. The lifestyle overview measures self-identified patient needs across the following domains:

- Phone communication
- Transportation
- Nutrition
- Physical activity
- Learning
- Housing
- Social support
- Safety
- Depression
- Tobacco
- Alcohol
- Drugs
- Legal
- Finances
- Work
- Medications
- Readiness to change

Members of an extended team provide a number of supplemental services, which are available only to Hennepin Health members. That team is a combination of directly employed staff and contracts with community partners, including:

- Social service and housing navigators
- Intensive case managers, with a focus on chemical dependency
- Emergency department “in-reach” workers
- Vocational service providers
- Community-based outreach workers
- Community paramedics employed by Hennepin County Medical Center

These additional services are targeted to the Hennepin Health members who use the most health care resources, because that is the place where interventions have the most potential to reduce medical costs.

Hennepin Health members with the most complex needs receive care in the Coordinated Care Center, an outpatient intensive care clinic. At the center, members receive care from onsite interdisciplinary teams. Patients are referred into the coordinated care center from other parts of the system, based on the complexity of their care.

Lessons learned

Outreach

Even the best-functioning clinic-based model cannot be successful if the target population is not using the clinics. Over time, Hennepin Health has developed a number of outreach strategies intended to link disconnected members to care teams in the clinic. Increasing our community presence outside of the clinic walls recognizes that changing care consumption patterns from acute care to primary care requires us to establish relationships by meeting our members where they are.

Comprehensive needs assessment

The services that Hennepin Health provides, including housing navigation and vocational services, were heavily informed by the results of the lifestyle overview tool. Asking members about their health and social needs is a crucial way to tailor the care model strategy, both at the individual and population levels.

Enrollment vs. attribution

The prospective enrollment model of Hennepin Health is very different from the predominant Medicare and commercial accountable care organization models, which are built on primary care attribution. In the latter models, health systems' accountability is limited by attribution to those who are already engaged in primary care. In contrast, Hennepin Health is held accountable for every prospectively enrolled person whether or not he or she has a relationship with our care model. This has created an imperative to contact members (especially high cost and high risk) and attempt to connect them to the care model via primary care. It has also revealed a reality that some of the costliest populations in our system are entirely left out of attribution-based accountable care organization models.

Analytics and data

A key strength of the Hennepin model is the ability to document most information related to patient care in a single electronic health record, which is shared across service areas. This has led to better integration of care and clearer connections between patients and the members of their care teams. In the course of their outreach work, Hennepin Health insurance plan staff and case management staff in Hennepin county human services now enter important patient information in one record that providers in the clinic and hospital use.

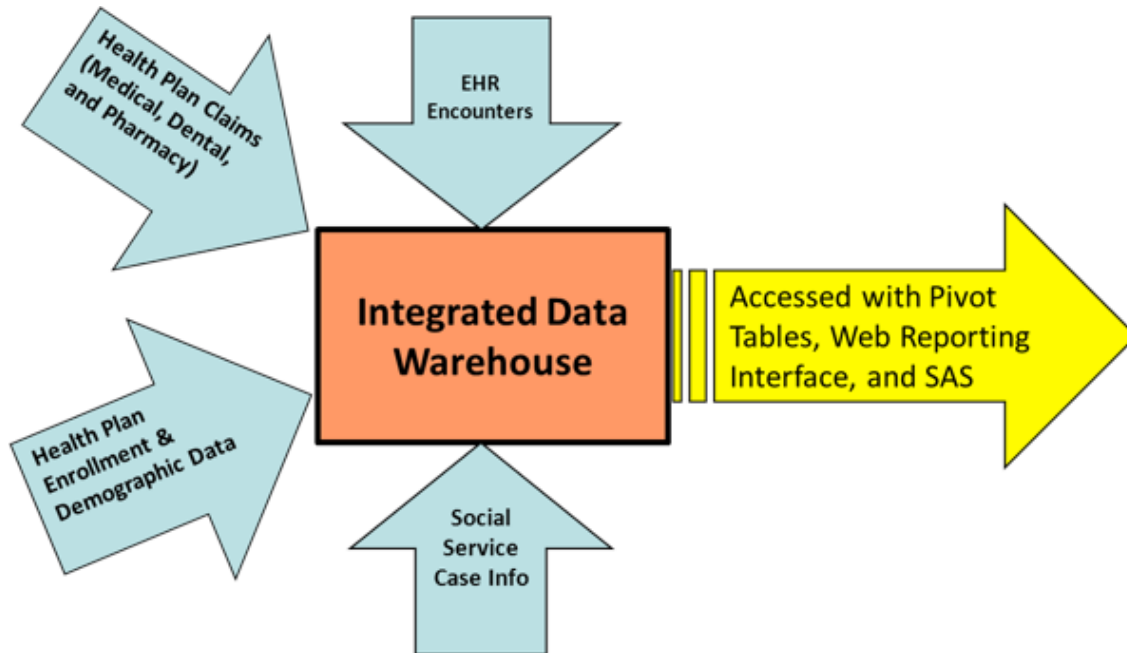
Hennepin Health has also created an integrated data warehouse (summarized in Figure 1), which eventually will eventually will host the majority of routine and ad-hoc analysis that once came from multiple, disconnected, data systems. The data warehouse contains:

- Enrollment and demographic data from Metropolitan Health Plan
- Claims data from Metropolitan Health plan, which reflect care provided at any site
- Electronic health record encounter data reflecting care provided by partners
- Social service case records from Hennepin county human services

Hennepin Health's integrated data warehouse represents a unique opportunity to more fully understand the breadth of members' involvement with different aspects of the health and social services system, and how services interact to influence outcomes.

Figure 1: Hennepin Health Data warehouse

Hennepin Health is actively engaged in data-driven population health management strategies, including using total cost of care, predictive modeling, and risk stratification information to connect members to interventions and prioritize finite resources.



Lessons learned

Data integrity: Combining data feeds from multiple sources in the Hennepin Health data warehouse has required diligent and ongoing attention to data integrity issues. In particular:

- Identity matching, so that minor variations in identifying information from multiple systems can be reconciled to avoid duplicate and incomplete records.
- Demographic information, to reflect the mobility and complex needs of Hennepin Health membership. Medicaid enrollment records often contain outdated information that makes contacting members impossible, and a significant portion of members have general delivery mailing addresses making receipt of mail unlikely. Duplicate or contradictory information in multiple systems often needs to be reconciled.

Analytic tools: As Hennepin Health's analytics needs are identified, partners have realized the importance of having appropriate tools with which to extract the rich data that is available. Depending on the needs and skill set of the person accessing the data, this need ranges from Microsoft Excel pivot tables for simple ad-hoc queries, to web-based reporting interfaces for scheduled, automated reporting, to direct access to source tables using statistical software.

Power in sharing data: Making previously unavailable data visible to members of the care team has led to large-scale changes in care delivery.

- Centralized documentation assists care coordination between systems
- Through health plan-generated data, clinic teams are able to view and assume management of a population of Hennepin Health members. Many of these members previously were invisible to them because they were not connected to clinic care. Information about the cost of care provides a system-wide view and can be used to prioritize available interventions.

Finance model

The alignment of financial incentives across the hospital, outpatient clinics, social services and public health has been integral to Hennepin Health's success. The price of component services is no longer the focus of the entities' business relationships; moving away from fee-for-service reimbursement means, for example, that fewer hospitalizations no longer represent lost revenue to the hospital.

Hennepin Health receives per-member, per-month capitation payments from the Minnesota Department of Human Services for enrolled members. The funds are managed by Metropolitan Health Plan (MHP), which operates as the program's administrator on a fixed percentage of revenue. Hennepin Health partners have agreed to a risk-sharing arrangement that shifts the remainder of the financial risk toward provider partners and dictates how gains and losses will be distributed. Provider partners continue to submit claims and are paid through contract relationships with Metropolitan Health Plan. Funds remaining are distributed back to the partners and into the system. Like other Medicaid managed care contracts in Minnesota, Hennepin Health has a percentage of its revenue withheld. Its return depends on improvement on a number of quality measures. These withhold measures are unique to Hennepin Health's population and are Healthcare Effectiveness Data and Information Set measures calculated by the Minnesota Department of Human Services.

The margin left over at the end of each contract year is used in two ways:

Direct distributions to individual partner organizations based on formulas that reflect each partner's relative size and agreed-upon performance measures.

Reinvestment initiatives to drive further system improvement. Hennepin Health staff identify and formally propose these reinvestment projects to the program's Operations and Finance committees, which determine the initiatives that will be funded. Projects are expected to have a short-term return on investment and measurable outcomes, which are used to determine whether funding will continue beyond an initial one-year period. Examples of reinvestment initiatives include:

- Leasing transitional housing units for medically complex homeless patients as an alternative to hospitalization
- Offering vocational services for high-cost behavioral health patients
- Developing a sobering center, to reduce inappropriate emergency department use by chronic inebriates

Lessons learned

Collective reinvestment

The Hennepin Health finance model's mix of direct financial incentives for partners and shared reinvestment projects has created a space and resources for new ideas to incubate and be tested. Reinvestment initiatives also allow the partners to invest in longer-term system changes that will be important for the program's long-term success, as their financial and quality benefits may take time to accrue.

Balance of incentives

The finance model ensures that Hennepin Health is not inappropriately limiting access or adversely affecting quality of care. Externally, quality incentives come from our contract with the state Medicaid agency. Internally, incentives come through self-imposed quality goals that determine the incentive money distribution.

Financial Reporting

Within the confines of managed care, it can be difficult to know how best to capture how dollars are flowing through the system and affecting patients in the process of care delivery reform. For example, use of community health workers in the clinics could be accounted for in at least three different ways, each with very different regulatory implications. They could be

- Funded directly from capitation revenue and reported as an administrative cost
- Billed through claims and reported as medical cost
- Funded through reinvestment dollars and reported as margin from a prior year

Governance

The formal legal structure binding the Hennepin Health partners together takes three main forms:

- The managed care contract between the Minnesota Department of Human Services and Metropolitan Health Plan doing business as Hennepin Health, which effectively makes all partners parties to the contract under Hennepin County's Health Maintenance Organization license with the state
- A memorandum of understanding, which articulates the high-level goals of Hennepin Health and the nature of the partnership
- A set of business associate agreements to facilitate the sharing of data within the project

Hennepin Health employs a small administrative team that provides dedicated leadership and staff support to the project across all partners. The remainder of the work is accomplished through the time and efforts of key members of each partner organization; a series of topic-focused committees drives input, design and implementation of Hennepin Health. The committee structure is as follows:

- **Collaborative:** A leadership oversight group consisting of the Hennepin Health Administrative team and chairs from each of the work groups
- **Operations committee:** Identified operations leads from each partner organization, focusing on practical operational issues and decision points
- **Care model committee:** A steering group focusing on the clinical and care delivery aspects of the program, both medical and social. Includes a care coordination subcommittee
- **Analytics committee:** A group focused on data and analysis issues, including the Hennepin Health data warehouse and electronic health record functionality
- **Finance committee:** Chief financial officers from each partner organization and key finance staff focused on tracking finances and determining the formulas for risk-sharing and performance among the partners. Includes a budget subcommittee
- **Research and publication committee:** A group focused on tracking and coordinating Hennepin Health in the academic and professional literature, and seeking opportunities to answer policy-relevant research questions
- **Privacy officers work group:** Designated privacy officers of each partner organizations, who handle issues of information privacy and security

Hennepin Health operates on the principle of consensus in decision-making. The program reports to a Policy and Steering Committee, the seven elected Hennepin County Commissioners and the executive leadership of the partner organizations. The committee serves as the ultimate arbiter and oversight body.

Lessons learned

Data sharing challenges:

Even though Hennepin Health partners are well-aligned around the goals of integration and coordination, the legal landscape surrounding which data can be shared, with whom, and for what purposes has been a source of confusion and caution. This has been particularly challenging in the area of social services, such as case management, housing, and food support, which is not regulated as health information and cannot be shared as freely, despite multiple patient consent forms and notices of privacy practices.

Value of consensus:

The operating principle of consensus has fostered considerable trust among Hennepin Health's partners as the program has matured. The governance structure has striven to create space for fair representation for all involved, and to focus on win-wins and the common ground that drives the reform agenda.

Regulatory challenges:

As a licensed managed care organization, Hennepin Health is subject to nearly all of the same regulatory requirements as other Medicaid managed care plans. A number of these requirements have little value in the context of a defined-network accountable care organization. Further, Hennepin Health's goals of moving away from fee-for-service provider reimbursement and developing nonreimbursable roles and services create challenges in a system of managed care rate-setting that is dependent on the traditional stream of claims data. Absent a national regulatory roadmap for accountable care organizations, Hennepin Health continues to work with its partners at the State of Minnesota to consider the most appropriate regulatory form for the program.

Outcomes

Hennepin Health tracks key triple aim outcomes via a monthly internal scorecard, aiming to simultaneously improve the patient care experience, improve the health of the population and reduce the per capita cost of health care. These measures align with outcomes tied directly to the Hennepin Health finance model, but which are more comprehensive and intended to guide the management of the program.

Figure 2:
Trends in health care use (from claims, 2012 vs. 2013)

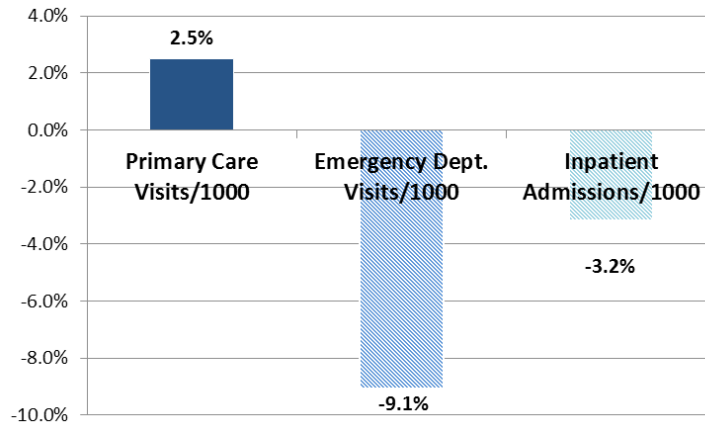


Figure 2 illustrates changes in how Hennepin Health members used health care services in 2013 compared with 2012, Hennepin Health's first year. As a whole, those enrolled in Hennepin Health used slightly more outpatient primary care over time, used the emergency department considerably less, and were admitted to the hospital slightly less often. These developments are encouraging signs that the model of care is effective, and that members are changing the way they interact with the health care system.

Figure 3:
Trends in quality of care: Change in percent of patients receiving optimal care (from provider-submitted Minnesota Community Measurement Data, 2012 [Jul-Dec] vs. 2013)

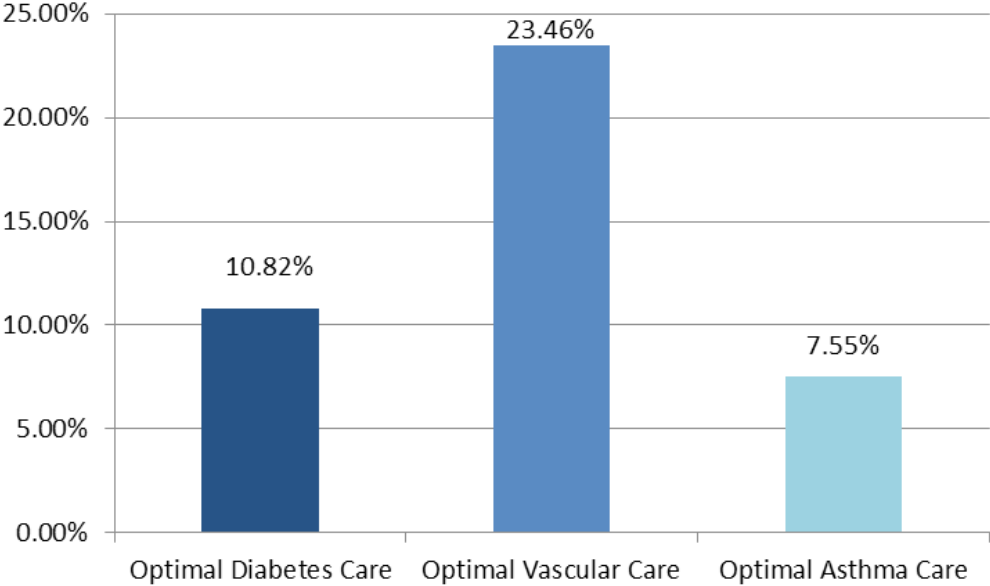


Figure 3 illustrates changes in the percent of Hennepin Health patients receiving optimal care for common chronic diseases. Compared to the second half of 2012, when Hennepin Health-specific data were first reported, in 2013 10.8 percent more Hennepin Health members with diabetes received optimal care; 23.5 percent more members with vascular conditions received optimal care; and 7.6 percent more members with asthma received optimal care. This improvement in chronic disease management suggests that quality of care is improving. However, actual rates of optimal care for this population leave considerable room for improvement.

Figure 4:
Trends in patient satisfaction: percent likely to recommend care (from Press-Ganey survey results, 2012 vs. 2013 [Jan-Jun])

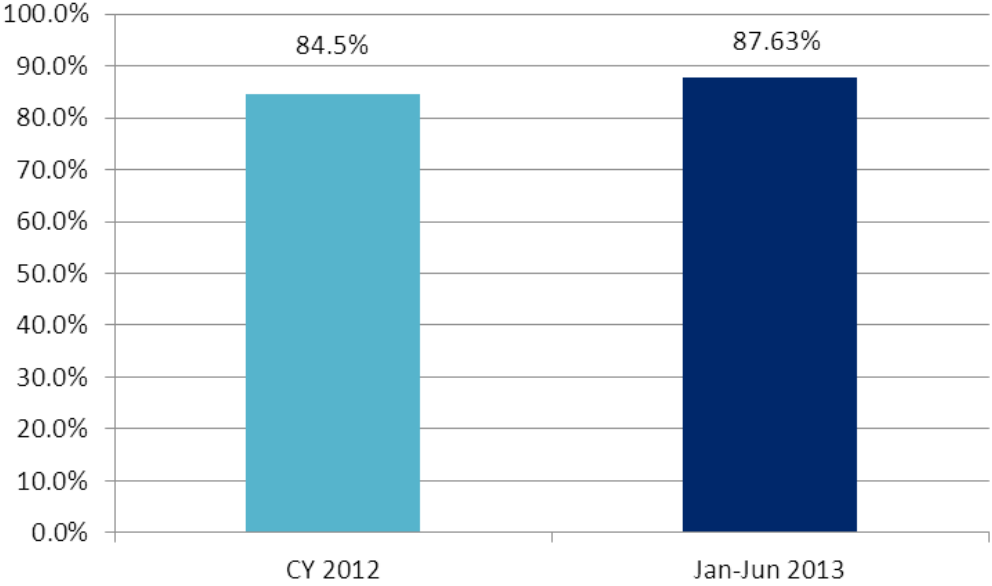


Figure 4 illustrates the percent of Hennepin Health members surveyed by Hennepin County Medical Center who indicated that they would recommend the care that they received to family or friends. Patient satisfaction as measured by Press-Ganey surveys has remained consistently high, and Hennepin Health members respond favorably at a similar rate as patient across the larger system.

Looking ahead

Hennepin Health is exploring how this approach to integrated care delivery and financing could be expanded to serve additional populations and how its lessons can inform health reform. Interest in Hennepin Health's approaches to improving care are particularly timely in 2014, with the rollout of the national Medicaid expansion made possible by the Affordable Care Act.

Through involvement in the State of Minnesota's Centers for Medicare and Medicaid Services Innovation Center State Innovation Model efforts, and through its partnership with the Minnesota Department of Human Services, Hennepin Health is advocating for models of health care delivery and financing that address social determinants for underserved populations and further integrate funding across services.

With continued flexibility in funding that allows greater service integration and innovation in care delivery, Hennepin Health plans to continue to explore the most effective ways to improve, in partnership with the population it serves.

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