Minnesota results show cost-cutting promise of patient-centered health care homes

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Minnesota was an early adopter of the use of health care homes, and a five-year study of their impact shows promising results for any state looking to reduce health costs and improve patient outcomes.

“Given how much is spent for Medicaid, Medicare and dually eligible enrollees, you can create large savings and bend the cost curve,” says Douglas Wholey, a professor of health policy at the University of Minnesota and the study’s lead evaluator.

The savings amounted to 4 percent to 4.5 percent per year over the five-year study period — for a total of about $1 billion between 2010 and 2014 — a rate that Wholey says is consistent with past studies of health care homes.

These reduced costs come from fewer hospitalizations, shorter hospital stays and fewer prescriptions. For example, over the five-year period, the rate of inpatient hospital admissions for Medicaid enrollees in a health care home was 77.3 per 1,000. That compares to 100.3 for Medicaid enrollees in traditional care.

This model of health care delivery (adopted by the Minnesota Legislature in 2008 as part of a larger package of reform) aims to provide better-coordinated and integrated services, especially for patients with one or more chronic diseases.

The goal in Minnesota has been to improve primary care across the state, in order to prevent costly chronic illnesses and provide appropriate early treatment.

Health care homes — called HCH clinics in Minnesota — provide patient-centered, coordinated care for all patient populations. Made up of doctors, nurses and other health professionals, these clinics either deliver the care themselves or work with other local providers. An HCH clinic receives a per-patient payment for coordinating care. By the end of the University of Minnesota’s study period, 40 percent of the state’s primary-care physicians were practicing in a certified HCH clinic.

According to Wholey, the successful implementation of health care homes was partly due to support from groups such as the Minnesota Medical Association and to the work of task forces appointed by the state’s political leaders. Another factor was developing certification standards, with community input, for health care homes. Minnesota is now refining the next generation of HCH clinics, again with input from the community.

The model has worked in rural and urban areas, the study found, though with local differences.

“Urban clinics could specialize in certain patients,” Wholey notes, “such as those with the most complex issues. The economics justify a specialized team.”

The federal Affordable Care Act permits states to submit a Medicaid state plan amendment to add health care home services as an optional benefit. To encourage states to do so, a temporary 90 percent federal match is available during the homes’ first two years of operation.
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