Health Care Home/Medical Home FAQs

What is a health care home?

A "**health care home**," also called a "**medical home**," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic or complex health conditions.

The development of Health Care Homes in Minnesota is driven by the Institute for Healthcare Improvement's Triple Aim, an initiative to simultaneously achieve the following goals: 1) improve the individual experience of care, 2) improve the health of the population, 3) improve affordability by containing the per capita cost of providing care. This model includes monthly payments to primary care providers for partnering with patients and families to provide care coordination. This coordination includes such things as telephone calls, reminder mailings, and consultations that occur whether the member goes to the clinic for an office visit or not.

What happens in a health care home?

When members are part of a health care home, they are encouraged to choose a primary doctor, physician assistant or nurse practitioner with whom they can develop a good and lasting relationship. They become a team that includes the primary provider and other health care professionals, as well as trusted friends or family members.

As a certified health care home, the provider will deliver care that is:

Care	Explanation
Accessible and Continuous	• The provider/clinic has convenient office hours for appointments with the primary doctor or nurse. • The provider/clinic makes it easy for members to get in touch with their primary provider. • The health care home team knows the member and their family. They can help manage total health care. • Members can see the same team each time they visit the clinic and can help answer your health questions.
Patient / Family-Centered	• The member and the primary provider work as partners to plan care.

How will members know if their provider is certified as a health care home?

The Minnesota Department of Health has developed a set of certification standards that a clinic must meet to be labeled as a health care home. Health care homes change the way care is delivered and accessed, building on primary care and the importance of a relationship between the patient, family members and care team. Health care homes focus on care coordination, team care, evidence-based medicine, and patient- and family- centered care. **Find a certified Health Care Home.**

Who can enroll in a health care home?

Members/patients with one or more chronic conditions are most suited for enrollment in a health care home. Providers invite patients to participate, when appropriate. It is up to the patient if he/she wants to participate or not.

For which products and plans are providers able to bill for health care home services?

Members in the following products and plans are included:

- Medica Choice® Passport
- Medica AccessAbility Solution® – Minnesota Health Care Programs (MHCP) Special Needs BasicCare (SNBC)
- Medica AccessAbility Solution Enhanced – MHCP Integrated-SNBC (I-SNBC)
- Medica DUAL Solution® – MHCP Minnesota Senior Health Options (MSHO)
- Medica Choice CareSM MSC+ – MHCP Minnesota SeniorCare Plus
- Medica Choice CareSM PMAP – MHCP Prepaid Medical Assistance Program
- Medica MinnesotaCare – MHCP MinnesotaCare

How much does it cost to be in a health care home?

There is no additional cost to the member to participate in a certified health care home. Medica is required by law to reimburse certified health care home providers through a monthly care coordination/care management fee for most health plan products.

Do members receive an explanation of benefits (EOB) each month?

Members, excluding those in a Minnesota Health Care Program (MHCP), receive an EOB each month that health care home care coordination services are billed. Certified health care home providers receive a monthly management fee for coordination of care whether or not the member goes to the clinic during the month for an office visit. Medica pays these negotiated fees directly to the provider. The member is not responsible for any copayment, co-insurance, or deductible. Providers should not balance bill members for Health Care Home care coordination payments.

Why are some claims not being paid even though the provider is a certified health care home provider?

If the provider is not setup in Medica's system to receive these payments the provider should contact their Medica contract manager and provide a copy of their certification letter from MDH. This is necessary to setup provider reimbursement for health care home care coordination fees. Medica needs a minimum of 60 days from receipt of the MDH certification letter to implement the care coordination codes for provider reimbursement.

If the patient is a member of a self-insured group that does not accept this payment methodology and pay for related services, claims may deny with member liability.

If a provider participates in an alternative contracting arrangement with Medica that arrangement may exempt the provider from the legislatively-mandated health care home payment amounts.

What claim denial reasons might providers experience?

Examples may include, but are not limited to:

- Member not active with Medica
- Member not eligible for program (only members with products/plans listed on page 2 are eligible)
- Not eligible charge - do not bill patient.
    - This could be the result of the provider not contacting their contract manager to inform them of their certification status.

How are services reimbursed?

Medica supports the Health Care Home payment methodology developed by the Minnesota Department of Human Services (DHS). Health care home providers submit a CMS-1500 physician claim form or electronic equivalent to initiate payment.

- This is not to be confused with Home Care Services providers who submit a UB-04 claim form for payment.
- Payment to the provider is considered a monthly per-member payment, regardless of if the member/patient is seen by a provider or not.
- There is no member liability for health care home or medical home services.
- Services are to be billed with a place of service.
- Certified health care home providers receive payment based on a tiered level of complexity using modifiers. Modifiers U1, TF, U2 and TG signify the level of complexity. Modifiers U3 and U4 signify additional reimbursement to the provider for patients with a primary language other than English and/or that have a severe and persistent mental illness. If both U3 and U4 happened to be billed in addition to one of the complexity modifiers, the total increase will be 30%. Rates are based on DHS fee schedules and adjust up or down according to DHS. The DHS base rates listed below are current as of the review date in the footer of this document.

Tier	Patient Complexity Level (DHS Base Rates)		Primary Language non- English = additional 15%	Severe and Persistent Mental Illness = additional 15%
	Physician	Nurse Practitioner/Physician Assistant		
1	Basic = $10.14 (U1)	Basic = $9.81 (U1)	U3	U4
2	Intermediate = $20.27 (TF)	Intermediate = $19.61 (TF)	U3	U4
3	Extended = $40.54 (U2)	Extended = $39.22 (U2)	U3	U4
4	Complex = $60.81 (TG)	Complex = $58.83 (TG)	U3	U4

Eligible CPT codes: Enter 1 unit of Initial Care Coordination planning code S0280 for the first month. Enter Maintenance Care Coordination Planning code S0281 for each additional month S0280, S0281.

- Providers using the Medica Medical Home payment methodology receive payment based on an agreed upon dollar amount on a per member per month (PMPM) basis. Thus far, the rate has been $50.00 PMPM using the G9002 code.

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