

# Health Care Homes

## Public Comment on Proposed Payment Methodology

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**Visit the MN Department of Health website for more information about Health Care Homes:**

<http://www.health.state.mn.us/healthreform/homes/payment/index.html>

**Instructions:**

- Please provide answers to the specific questions below.
- Where possible, please use the left-hand column to indicate which content area (numbered 1-3) your comment refers to. If your comment encompasses multiple areas you may leave this field blank.

**Type all comments and e-mail this form by December 4, 2009 to: [DHS.HCH@state.mn.us](mailto:DHS.HCH@state.mn.us)**

<b>Content Areas for Feedback:</b>	<p>On behalf of the Minnesota Hospital Association's members, which include 148 hospitals and 17 health systems in Minnesota, I offer the following comments regarding the health care home payment methodology recommendations.</p> <p>The Minnesota Hospital Association (MHA) supports the health care home initiative and has appreciated the opportunities for MHA and our members to participate in the work groups that discussed these payment methodology issues. As with comments that MHA submitted pertaining to other health care reform initiatives, we are concerned that the brief window of opportunity for public comment is insufficient to ensure that the state receives broad and complete input from providers and the patients they serve. Accordingly, MHA offers these comments and reserves the right to provide additional feedback to the Minnesota Department of Human Services (DHS) as our members bring additional questions or concerns to our attention.</p>
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## **1) Patient Complexity Stratification and Methods for Minnesota Health Care Program (MHCP) Rate Development**

Throughout the various health care reform initiatives, MHA and other stakeholders have questioned how DHS and the Department of Health (MDH) will coordinate decisions among the different initiatives, work groups, committees and staff support. MHA's concern is that the Provider Peer Grouping Advisory Group recently recommended that the state use an apparently widely-used commercial product to define episodes of care and the health care home payment work group is recommending a different methodology to define complexity. While it is possible and entirely likely that using different methodologies in these ways is appropriate, it is unclear, however, if and how the state is coordinating the activities between multiple reform initiatives to ensure that it adequately and thoughtfully addresses any potential for confusion, inconsistent results, additional costs or unnecessary complexity before committing to adopt either recommendation.

Another concern MHA members raised is that MDH recognizes that the ADG data for risk stratification is often six months old and may not adequately address the complexity of patient care on a "current" basis. However, this data and stratification tool are potentially problematic. The Johns Hopkins risk stratification tool fails to account for patients with multiple but stable conditions. Thus, those patients are not appropriately moved up a level for calculating the provider's care coordination fee. In other words, the Johns Hopkins tool regards a patient with four stable conditions as equivalent to a patient with one stable condition for purposes of categorizing the amount of care coordination required by the provider. MHA encourages the state to revise the tool to ensure that a patient with multiple but currently managed conditions will warrant a higher care coordination level than another patient with only one stable condition.

From the data included in the recommendations, it appears that there is significant variation between the median and mean total costs, which seems to indicate that there are substantial high-cost outliers. When setting the care coordination fee amounts and ultimate methodology, MHA encourages the state to take the evidence of these dramatic outliers into account to ensure that the payments to providers compensate for the additional coordination required to appropriately care for patients with these complex, high-cost needs.

MHA applauds the recommendations recognizing the additional coordination costs and challenges for providers delivering health care home services to patients who don't speak English as their primary language. That said, MHA suggests that DHS consider those English-speaking patients with lower health literacy skills because they can present equally challenging and costly care coordination demands for providers. As further care coordination fee payment rates and methodologies are developed, MHA encourages DHS to consider health literacy levels, as well as English-speaking abilities, as a factor for adjusting payment amounts.

Further clarification of the payment adjustments for patients whose primary language is other than English and patients with major, active mental health condition would be helpful. In particular, it is unclear whether the work group recommends that the care coordination payment should be adjusted by the same amount or, instead, whether the state will further refine the recommendations to create different adjustment amounts for patients with major, active mental health conditions than patients whose primary language is other than English.

## **2) Clinic and Payer Communication Processes for Care Coordination Payments**

Generally, MHA supports the recommendations put forward by this work group. While the health care home initiative is a new endeavor, MHA suggests that DHS strive to simplify the administrative process, burdens and costs to create the best possible chance for the initiative's success.

Likewise, MHA is concerned that the recommendations could result in additional documentation requirements beyond those necessary to become certified as a health care home. More specifically, the concern is that the state will create a situation in which providers will develop documentation procedures necessary to meet the certification criteria without meeting all of the documentation requirements necessary for the care coordination payments. Thus, MHA suggests that DHS ensure that the documentation and other procedural requirements necessary for the care coordination payment process are aligned with or identical to the certification criteria, and that providers seeking to become certified as health care homes have clear and unambiguous information about the requirements they must meet to receive the care coordination payments.

## **3) Consumer/Patient Payment Considerations**

MHA supports the work group's recommendations that patients should not bear cost sharing obligations for health care home services. Because this is a new initiative, it is particularly important that patients do not perceive barriers or disincentives to receiving the health care home services.

Likewise, MHA agrees with the work group's sensitivity toward and concern about the use of private patient information used to assign a payment rate. The work group appropriately identified the need for protection of sensitive clinical and socioeconomic data on behalf of patients. MHA believes that even stronger protections are necessary to ensure that health care home patients are assured that these highly sensitive pieces of information remain private and secured. MHA is willing to work with DHS and other concerned stakeholders to develop more specific limitations and protections for these data elements.