

Health Care Homes

Notice of Intent to Adopt Expedited Rules without a Public Hearing

Name of Person Submitting:	Matthew L. Anderson	Date: Aug. 6, 2009
Organization	Minnesota Hospital Association	

Visit the MN Department of Health website for more information about health care homes

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

Instructions:

- Provide general comments in the first input field or provide a letter with general comments.
- Include detailed suggestions for changes in scope and/or rule content in the next section.
- Comments should include statements describing your rationale for the desired change. For example, rather than noting a particular statement is confusing, state why it is confusing or if it is unclear what specific concept is unclear.
- If the comments involve questions or clarifications with a scientific basis for part of the rule, please include the scientific rationale for the comment and literature citations if available. Please provide MDH with a copy of any cited article.
- Positive comments and identification of specific areas that are helpful is important to include too.

Type all comments and e-mail this form by August 6, 2009 to: health.healthcarehomes@state.mn.us

General Comments about health care home draft rules:

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 proposed health care home certification rules.

The Minnesota Hospital Association (MHA) supports the health care home initiative and has appreciated the opportunity to participate in the work groups that discussed potential standards and criteria for certification. MHA applauds the Minnesota Department of Health and Department of Human Services (DHS) for drafting rules that strive to give providers greater flexibility to design and innovate within the health care home structure.

At the same time, MHA remains concerned that the departments have put forth criteria and standards for certification before developing the entire health care home framework, particularly the details of care coordination payments, so that our members could evaluate whether the rule's requirements are reasonable in light of the potential reimbursements. While elements of the proposed rule may seem reasonable in the abstract, if the care coordination payments are limited to too few patients or are set at

low amounts, then the obligations and burdens described in the rule become onerous and objectionable. In other words, it is impossible to evaluate whether the rules establishing criteria and standards are reasonable without knowing what revenue will be available to support the underlying work required to meet those standards and criteria.

The following comments raise issues or concerns about the draft rule generally and are followed by comments specific to various enumerated provisions in the draft.

Throughout the proposed rule, references are made to communication with a patient's family, family-centered decision making, and other indications that family members will be involved in a health care home patient's medical decisions. MHA supports patient- and family-centered care as frameworks for improving patient care and experiences. However, MHA believes that language clarifying that providers' certification is not dependent upon involving family members or others in the decision-making process without the patient's consent and reaffirming that ultimate decision-making authority continues to rest with the patient as set forth in current law. In other words, the proposed rule should be revised to clarify that it does not change Minnesota law regarding medical decision-making and who has authority to make medical decisions on behalf of a patient. This will ensure that patients retain their control over their medical treatment and care and protect providers from unnecessary concern about whether their health care home certification or eligibility for care coordination payments will be jeopardized if a patient does not want family members involved in the decision-making process.

Likewise, MHA urges the departments to revise the proposed rule to clarify that discussions between a patient and a provider are entitled to any and all evidentiary privileges as afforded under current law even if family members participate in those discussions as part of the health care home's family-centered decision-making. In other words, if family members and patients will be consulting with a health care home provider to make medical decisions through the family-centered decision-making process, their discussions with the provider should be entitled to protection from discovery, subpoena, or other legal compulsions of disclosure and treated as confidential under patient/doctor privileges.

In order to make the certification process more streamlined and efficient, MHA suggests revising the proposed rule to align the timing of recertification with a provider's licensing or credentialing process.

The rule does not specify whether applicants will be required to pay an application or recertification fee. If the departments intend to impose such a fee, they should include the proposed fee amount(s) in the rulemaking process and provide stakeholders with an opportunity to comment.

Hopefully these comments help the departments revise the rule in a manner that will make it more clear and move the health care home initiative closer to a successful undertaking by the state. If you have any questions or concerns about any of the comments or would like to discuss them further, please feel free to contact me anytime at (651) 659-1421 or manderson@mnhospitals.org.

Draft Rules Feedback:	Sections 4764.0010 Applicability and Purpose 4764.0020 Definitions 4764.0030 Certification and Recertification Procedures 4764.0040 Standards 4764.0050 Variance 4764.0060 Appeals 4764.0070 Revocation, Reinstatement and Surrender
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Rules Section	Subpart	Letter, #, Letter	Comments, Concerns, Questions	List references to support recommendation
0040	4	A.1.a	The description of your question, concern, or comment. Please be specific, describe the change or concern here.	Example
0020	11		The use of “treatment or interventions across a broad scope of medical, social or mental health services” makes the definition both vague and unduly broad. Interventions are not defined in the proposed rule and, therefore, could mean almost any act or effort by the patient or others without limitation. In total, the definition could be interpreted to apply to any patient with multiple medical conditions since they will inevitably involve medical, social or mental health “treatments or interventions.” On the other hand, one could argue that the definition is far too limiting if the use of the phrase “a broad scope” is intended to mean a large array of services. Because either interpretation is plausible and consistent with the language used, the definition is vague and should be further clarified.	
0020	19	A	The definition of “family” for patients 18 and over should include a patient’s spouse. As noted above, the definition should clarify that the rule does not change existing law regarding authority for making health care decisions on behalf of another.	
0020	30		The definition of “primary care” is overly broad by including “overall and ongoing medical responsibility for . . . comprehensive care for preventive care and a full range of acute and chronic conditions, including end of life care” The scope of the definition could be interpreted as creating responsibility for the health care home to deliver or assume responsibility (and consequently liability) for complete comprehensive care. It is beyond the scope and contrary to	

			the intent of the health care home enabling legislation to extend primary care providers' liability to all care delivered to a patient. The definition should be modified to specify delivery of primary and preventive care services and coordination of comprehensive services without assigning responsibility or liability to the primary care provider for care delivered by other providers.	
0020	32		Given existing technology and further adoption of electronic medical records, the definition of "referral" should not be limited to "written documentation." Or, if the Departments insist upon the use of "written documentation," they should add a subpart defining "written documentation" in a manner that includes electronic communication and referrals.	
0020	33		The proposed definition of "shared decision-making" does not appear to differ significantly from existing informed consent requirements. By creating a new concept with substantially indistinguishable requirements for providers, the rule could exacerbate informed consent litigation by creating a new cause of action under substantially similar facts and law, but without the long precedential history of existing case law. Thus, the definition creates the potential for confusion with the informed consent process as well as the proliferation of litigation. The term should not be used in the rule or, if it must be used, its definition should be clarified to distinguish the required informed consent process from the new shared decision-making process.	
0030	3		The authority of the commissioner to conduct on-site reviews and request additional documentation needs further definition and limitation. As proposed, the rule could be interpreted to give the commissioner unlimited discretion whether to conduct an on-site review. Likewise, her ability to request additional documentation and the type of documents she can request are not limited to those that are relevant for making a determination on the health care home certification. The rule should be redrafted to describe the circumstances under which the commissioner can conduct an on-site review or request additional documentation to prevent abuses of power, targeted exercise of regulatory powers, or the use of on-site reviews or documentation requests as fishing expeditions.	

0030	4		Because other deadlines in the rule are calculated from the date of the submission of a completed application, it is important for the rule to specify when a completed application is submitted so providers can plan accordingly. However, the commissioner's ability to conduct on-site reviews and request further documentation is unlimited both in terms of the scope of documents she can request (see above), the number of requests she can make and the amount of time in which can request them. Accordingly, it is impossible for an applicant to know when a complete application has been submitted and the clock for other timelines begins because the commissioner has the ability to request further documentation at any time.	
0030	5		The proposed rule would require health care homes to get recertified every year. In order to make the health care home certification more attractive to providers, cheaper to administer for the department and more reliable for patients, the rule should allow providers who have been health care homes for two consecutive years to receive two- or three-year recertifications.	
0030	6		Before adoption, the rule should clarify that the benchmarks announced annually are for prospective use only and newly announced benchmarks cannot be used to assess previous performance for making recertification determinations. Otherwise, a health care home applying for recertification could be held accountable for its historical performance on benchmarks that are announced by the department shortly after the provider submits the recertification application. As a simple matter of due process, health care home providers should know which benchmarks the department will be used to evaluate their services before they deliver those services rather than having their services judged retrospectively based on benchmarks that were unknown or undesignated at the time services were delivered.	
0030	7	C	The proposed rule does not clearly address whether a provider whose application is denied can reapply without appealing the denial or if an applicant is precluded from applying for a certain period of time following a denial. The rule should be clarified to state that the provider may file an appeal or reapply for certification.	

0040	1	E	<p>Requiring health care homes to inform patients that they can obtain specialty care services without regard to whether the specialist is a member of the same provider group is unnecessarily restrictive. As a provider develops its health care home team, it might decide to include specialists to participate in the care coordination and management of the patient, particularly when caring for patients with chronic diseases and complex conditions. Requiring health care homes to instruct patients that they can obtain those specialty services from non-team members would undermine the provider's efforts to coordinate and manage care within the health care home setting. MHA encourages the departments to eliminate or rewrite this provision to allow a health care home to manage its patients' care with its care coordination team and specialists, while recognizing every patient's freedom to choose care from the provider of his/her choice.</p>	
0040	2		<p>The proposed rule would require applicants to demonstrate improved participant involvement and communication by addressing "participants' readiness for change, literacy level, or other impediment to learning." These standards are undefined in the draft rule, vague and presume a level of patient-provider engagement that is unrealistic and potentially costly. Providers should not be expected to address a patient's literacy level or other impediments to learning. At most, a provider could be expected to address a patient's <i>health or wellness</i> literacy, but the provision is not so limited or confined. Likewise, addressing any "other impediment to learning" is an unusually broad burden to place on health care providers. This obligation for recertification should be eliminated. If the department believes it is necessary, it should be rewritten to limit the health care home's obligation to addressing its patients' health literacy, their readiness for change with respect to behaviors that impact their physical or mental health, or other impediments to improving their health status.</p>	
0040	3	B.2	<p>The proposed rule would require health care homes to develop patient registries with "sufficient data elements to issue a report" The proposed rule does not specify to whom such a report is issued or whether providers are required to submit the report to the state,</p>	

			provide it to the participant, use the report within the health care home, etc. The use of the report or recipient to whom it must be issued should be specified with appropriate limitations on the use of the information contained in the report. If there is no specific use for the report, this provision should be eliminated so that providers are not responsible for incurring costs necessary to build capacity to issue unnecessary and unused reports.	
0040	4		The proposed rule would require health care homes to make statements against interest which could be used in civil or criminal litigation. Requiring health care homes to identify “gaps in care” creates discoverable evidence that trial attorneys could argue are equivalent to admissions by the provider that its care was substandard, which is not the departments’ intent. Despite their intent, the rule’s language creates a risk that health care homes will be at a significant disadvantage in defending malpractice claims. As an alternative, the departments should consider eliminating the provision entirely or rewriting it to require applicants for recertification to demonstrate continuous improvement in their efforts to remind patients about upcoming or needed appointments and to utilize pre-visit planning.	
0040	5	C	Requiring the health care home to locate the care coordinator “at the same site as the personal clinician” is unnecessarily restrictive, will decrease efficiencies for health care homes, and will decrease provider collaboration to provide health care home services in less densely populated areas of the state. Requiring care coordinators and providers to have direct communication is appropriate, but technology allows for direct oral and written communication without being located at the same site. The rule should be changed to allow providers to innovate and create structures in which a care coordinator could work with multiple personal clinicians in different locations. Doing so would allow providers in rural areas of the state, for example, to use a care coordinator in one location to provide services to patients that may use different clinics throughout the region, or to allow large provider groups to locate care coordinators together so they can learn from one another while working with clinicians serving patients at multiple locations within the health	

			system. With this new initiative, the departments should allow providers and care coordinators the freedom to develop the necessary communication while maximizing efficiency and flexibility.	
0040	5	D	The proposed rule's requirement that a health care home provide "dedicated space and time" to care providers should be further clarified to ensure that health care homes are allowed to enter into job-sharing or other work force arrangements with care coordinators who share the same space. Likewise, the rule should be revised to clarify that the "dedicated . . . time" provision does not require a provider to set aside specific hours when the care coordinator undertakes care coordination activities and no other tasks. Health care homes should remain flexible so that they can manage their care coordinators' time. Moreover, dedicated time implies that a care coordinator would not engage in care coordination activities outside of that dedicated time. Obviously, this would interfere with and undermine patient care if the care coordinator is unavailable to take a patient's call, review a patient's schedule or answer a patient's question if it occurs outside of the "dedicated time" allotted for care coordination even though the care coordinator is at work and able to perform those functions.	
0040	5	E.6	The proposed rule should be revised to add the patient as a decision-maker with the care team when determining which external care plans are beneficial to care coordination.	
0040	8		This provision should be revised to clarify that the health care home will collect and consolidate information from only those external care plans for which the patient has provided prior consent or authorization. In a patient-centered care model, patients should retain authority and sole control over what external sources of information are provided to the health care home. Likewise, health care homes should not be held responsible for collecting or consolidating information from external care plans that the patient has not disclosed or provided authorization of release to the health care home.	
0040	9		The proposed rule would impose performance reporting and quality improvement obligations on "the applicant for certification." Applicants who have not yet been certified should not be obligated to comply with any performance reporting or quality improvement	

		<p>standards in the rule unless and until they receive certification as health care homes. Merely applying for certification should not result in additional burdens and reporting obligations in the absence of or prior to certification and eligibility for care coordination payments. In particular, applicants should not be required to hire care coordinators, participant representatives or incur other expenses while their application is pending. Instead, they should be allowed to avoid those expenses unless and until their application is granted, in which case certification and care coordination payments would be contingent upon the provider meeting those conditions.</p>	
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Type all comments and e-mail this form to: health.healthcarehomes@state.mn.us