

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

Content Areas for Feedback:	1) Patient Complexity Stratification and Methods for Minnesota Health Care Program (MHCP) Rate Development 2) Clinic and Payer Communication Processes for Care Coordination Payments 3) Consumer/Patient Payment Considerations
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1.) Which elements of the proposed payment methodology are unclear? (Detail and rationale explaining why something is unclear are appreciated.)

Content Area (if applicable)	Comments
2	<p>Thank you for the opportunity to respond to this report. We recognize the many hours of effort from Working Group members and staff that went into developing the recommendations.</p> <p>Please clarify steps A-C in Recommendation 1: Key Process Steps. It seems that, first, practices need to "implement a method of screening" to identify potentially eligible patients, which may include a "predefined standardized tool." Then they need some kind of ICD9-ADG translator tool to place patients in tiers. Then they need to make the determination whether each patient qualifies for the percent "bump" in payment for having one or both of the designated nonmedical complexity conditions. If this is indeed the process being proposed, it represents a costly and time-consuming task that would likely be done at a central administrative level within large medical group systems. Small independent practices will need significant assistance or may be prevented from participating altogether. Also, this process will add to a practice's administrative costs rather than enhancing or increasing direct care and coordination.</p>
1	<p>It is not clear whether a tool has already been developed and tested to support clinics in "translating" an ICD-9 problem list into the type and number of ADGs for tier assignment. Even if it has, how will distribution and training at the practice level be accomplished by July 1, 2010?</p>
1	<p>Final payment methodology materials must decisively address the issue of care coordination services overlapping with activities that are currently being reimbursed on a fee-for-service basis.</p>

2.) What steps can be taken regarding the payment methodology to make it easier for you and your organization to participate in the Health Care Home initiative?

Content Area (if applicable)	Comments
1, 2 & 3	<p>All three reports and recommendations should be combined into one comprehensive document that it is internally consistent and clear, particularly with regard to the definition of patient complexity and how that relates to eligibility for HCH and care coordination. We assume all 3 reports were using the same ADG-derived complexity tiers, but that needs to be made explicit.</p>

1 & 2	Rather than having the practices take initial responsibility for identifying the tier to which their members belong, the MAFP proposes that health plans be given that responsibility. According to Report 1, page 4 “all participating payers use ACG software currently,” so the plans already have the necessary information, whereas practices do not. This would eliminate a substantial burden on providers by giving them a list from which to prospectively identify and enroll patients who are eligible for HCH and care coordination payments. Practices could verify the accuracy of the health plan’s assessment and could choose to enroll all or a subset of eligible patients.
2	If practices are given the initial responsibility to screen patients for eligibility and place them in complexity tiers, as described in the current documents, the methodology must be structured to provide practices with timely confirmation of patient tier classification. It must prevent providers from retrospective denial of care coordination payments for patients that health plans would classify in a lower tier.
3	We strongly support the Consumer/Patient Payment Considerations Work Group’s statement “In addition, while implementing a health care home should be transformational in a clinic and practice, the goal should also be to try to make it easy for the provider to receive payment for care coordination.”
	Payment methodology requirements should not duplicate requirements for HCH certification. Any overlap should be eliminated so that if a HCH is certified, payers can assume that general expectations are met. This is a key factor in reducing administrative burdens for practices so they can focus on patient care.
3	We believe that to transform health care in Minnesota, the HCH needs to be “baked in” to all clinic and payer processes in order to be “baked in” to the patient experience as recommended by the Consumer/Patient Payment Considerations Work Group.
3	We support the Consumer/Patient Payment Considerations Work Group’s statement that “. . . if providers have to determine a patient’s insurance eligibility for care coordination payment in order to provide needed care coordination services, it would be a barrier to the spirit of health care home and the primary provider’s desire to provide quality care.”
3	It would be helpful if the final methodology communication could speak to the commitments or responsibilities of patients who agree to participate in a HCH. Issues of patient motivation and compliance will have significant impact on the success of HCH implementation and corresponding cost reductions. We strongly encourage development of system-wide methods that engage, motivate and activate patients, ideally as a partnership between payer, provider and patient. Finally, consideration needs to be given to addressing non-compliant or unwilling patients because they will still be included in a HCH’s patient population for measurement purposes.
	An important component in successful long-term implementation of HCHs will be to assure that the payment methodology will strongly encourage payers to be consistent in their processes from year to year and that continuity is maintained among payers across several years. This will maximize opportunities for practice transformation and reduce interruption of patient care due to annual contract changes.
3	Practices will need guidance/resources for developing contracts or outlining expectations for patients and non-primary care specialties.
3	We strongly agree with the second recommendation under Deliverable 2 that detailed assessment information, “containing sensitive clinical and socioeconomic information should not be submitted routinely to the payer for billing purposes.”

3.) What additional barriers or problems exist related to the payment methodology in order for the Health Care Home initiative to be successful?

Content Area (if applicable)	Comments
1	Paying for start-up costs for practices is still not addressed adequately. If no money is available, then the administrative burdens at start-up need to be reduced.
HCH Payment Methodology Principles (dated 11/16/09)	We disagree with the first principle of HCH Payment Methodology that says: "Payers will independently negotiate care coordination rates with HCH providers within a common framework and structure." Ideally, providers would offer their HCH services to all patients in their areas so this principle creates additional effort on the part of providers with no direct benefit to patients. From the standpoint of providers, having to negotiate care coordination fees with each plan is burdensome if not unworkable. There is potential for significant inconsistency in reimbursement, along the lines of the variation in cost reporting figures published by MNMCM. If care coordination rates are indeed governed by a "common framework and structure," they should be transparent and easily applied without having to go through a negotiation process. Again, small practices that are not typically "at the table" for high level negotiations could be significantly disadvantaged.
3	We agree with the recommendation that there be no member financial liability (cost-sharing) for members of State Public Programs who participate in HCHs. We encourage commercial programs to follow suit, because patient surveys conducted by the Minnesota Chapter of the AAP and the MAFP under a contract with MDH have shown that additional fees for participation in HCH will be a barrier to patient participation.
	Health plans should consider transferring dollars currently used for disease-specific case management services into care coordination within HCHs. Local and personal care coordination of the whole patient is essential for quality, cost saving and patient engagement.
	We are concerned that DHS is using ICD-9 coding, MDH is using ADGs for HCH and then ETGs for provider peer grouping will lead to inconsistent value being assigned to care management results. Standardized reporting is critical to measuring results.

4.) General comments and feedback on the payment methodology.

Content Area (if applicable)	Comments
	<p>Every person deserves a Health Care Home and all patients will benefit from continuous care coordination. The MAFP continues to advocate for care coordination fees for all patients, even if the amounts are modest for “Tier 0” patients. Care coordination fees for all tiers would be consistent with the “baked in” nature of HCHs recommended by the Consumer/Patient Payment Considerations Work Group. “HCH for all” will not only benefit patients, it will reduce costs. We understand the emphasis on cost savings through care management of the most complex patients. However, we must not lose sight of the fact that for less complex patients, care coordination can prevent illness before expensive care is needed. For example, a well managed (low tier) hypertensive or diabetic patient who receives appropriately aggressive care management will have the potential for huge savings over a lifetime by preventing progression to costly complications and avoiding higher care coordination fees in Tiers 3 and 4.</p>
	<p>We strongly believe that successful implementation of HCH throughout Minnesota will benefit patients and providers as well as save money. We want to stress that HCHs are more than just focused care coordination. The HCH is also specifically meant to reinforce patient-centeredness concepts, seamless care through longitudinal provider-patient relationships, comprehensiveness in care, enhanced access mechanisms, and QI processes. Payment amounts should recognize that additional services provided by certified HCHs will include enhanced access and communication, patient and family-centered care and continuous quality improvement.</p>

THANK YOU! Your feedback and engagement are crucial to this effort.