

**Health Care Homes Chart of Public Comment
Comments with MDH Response
Formal Comment Period: July 6, 2009 – August 6, 2009**

Rule Part 0010: Applicability and Purpose						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response
1	1	A	1.9	It will be important to keep the cultural needs of specific patients in mind as the process is communicated. How the health care home is communicated to communities of color, immigrants and refugees is as important as what is communicated.	Center for Cross-cultural Health, Sandra Eliason	We will address cultural awareness through training.
2	1	B	1.12	How the process is implemented is the most important element. Many patient communities have a great distrust of having their names in any type of registry or central listing. Establishing trust that a registry will not be used for purposes that will harm the individual and/or the community is very important. All consideration must be given to ensuring that trust will be built within the community that any registry is not only acceptable, but beneficial. It is also important to assure the community who will have access to the registry and for what purpose.	Center for Cross-cultural Health, Sandra Eliason	We will address cultural awareness and patient- and family-centered care through training.
3	1			This has to be primary care: family medicine, internal medicine, pediatrics; I think you might have everyone trying to be and qualify as a medical home and the intent of this movement is to put care in the hands of primary care, (and reward/reimburse primary care) as this is where the evidence has shown the cost savings.	NorthPoint Health and Wellness Center, Paul Erickson, MD	According to MN Statute 256B.0751, Subd 2 (a) (1):The standards ... must emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians. We will address the standards through training.
4	2			Since this section is the applicability and purpose it should be more clear who is an eligible provider	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	The term "eligible provider" is defined and the criteria are in the standard and definition. Purpose focuses on the standard.
5	2	B		Cost of development or purchase of electronic registry may be prohibitive for small independent practices. If a clinic has an EHR it may not have a true registry function resulting in retro-engineering or report generating application overlay, hence high cost.	Northstar Physicians Network, Bruce Penner, RN	No change. They may seek a variance. There is a wide range of acceptable methods to meet this requirement.
6	2	C, D		How does this correspond with existing state and federal rules regarding patient information	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Nothing in this rule alters existing state and federal confidentiality rules. We will address confidentiality and patient information through training.
7	2	D		Should drop selected, so it would read, "include a care plan for patients with chronic or complex conditions (s is missing)	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	We recommend no change. See 4764.0040, Subp. 7 A. establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. The word "selected" relates to the policy requirement in 4764.0040, Subp. 7 A and the

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						"s" is appropriate grammar.
8	2	E		Certain chronically ill, aging individuals will not improve in health, no matter what the inputs of care and attention. What prevents such patients from being discriminated against, as having a registry full of such individuals would not demonstrate a continuous positive improvement for the provider at their Health Care Home?	Seven County Senior Federation, Lisa A. Krahn	We recommend no change. In 4764.0020 Subp. 24 "outcome" means a measure of improvement, maintenance, or decline as it relates to patient's health status, patient experience, or measure of cost-effectiveness in a health care home. See 4764.0030, Subp 5 B.3- the benchmarks established by the commissioner for improving the quality of services based on patient health outcomes, patient experience outcomes, and outcomes related to cost-effectiveness in its primary care services patient population have been achieved. Measurement of the entire clinic population prevents such patients being discriminated against because of the requirement to provide measurement for the clinic's entire population in order to achieve future certification. Outcomes measurement will be risk-adjusted for population severity of illness and non-medical complexity.
9	2			The purpose set out under Rule 4764.0010, Subp. 2 does not state the purpose of health care homes but instead identifies the services that health care homes are required to deliver.	Minnesota Governor's Council on Developmental Disabilities, Minnesota Department of Administration, Colleen Wieck	We reviewed 0010 Subp. 2. and believe that it meets the intent of the legislation.
10	2			Pleased review definitions of conditions and outcomes throughout this document and add objective criteria. Define the standards tightly and the procedures or methods loosely (currently reversed) if you would like Minnesota to drive the formation of an optimal medical home.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Our charge is to implement the standards and criteria of Health Care Home.

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11	3		2.1	How trust is built will be the key to engaging the participant. Contact with the individual and/or community member(s) must not be seen to be self serving, but to meet the individual and community's needs and to serve their interests in better health for themselves and their families. The importance of the health care home will be where it is a "with" the community members and not a "for", to foster personal responsibility for care and improved outcomes.	Center for Cross-cultural Health, Sandra Eliason	So noted. Patient- and family-centered principles will be addressed in training.
12	3			In reference to "care coordination" the wording: "engages participant" seems weak, it should indicate a stronger role for the participant, like the participant as an equal partner on the team. The definition should end at "continuity of care"; the reference to trust should be stated strongly in the definition of patient and family-centered care, the basis for health care home.	Family Voices of Minnesota, Ceci Shapland and Board of Directors	Please see the changed definition of patient and family centered care. "Trust" remains as it relates to the key principle of family and patient centered care. Partnership is already addressed in patient and family centered care principles.
13	5			Do not define or mandate additional labor force if existing or newly designed care delivery models can achieve all the objectives included in Subpart 3.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	No change. There are no mandates for additional labor force, only requirements for new functions. Those functions may be done within the current labor force.
14	5			Care Coordination should be a defined set of functions and not a person. Care coordination is currently being done in various forms in most primary care clinics. Many functions may be better done by nursing staff that already have a good relationship with the patients. This is much more achievable and potentially more productive. Also, if an independent clinic is a member of a network or an independent practice association (IPA) that can perform support services, consideration should be given to allowing the network to either organize or provide care coordination functions and/or personnel across multiple providers/sites/clinics.	Northstar Physicians Network, Bruce Penner, RN	Care coordination functions are outlined in 4764.0040 Subp. 5 and these functions will be addressed in training.
15	6			Written Documents Part 4764.0020, subpart 6, defines a care plan and subpart 32, defines a referral as "a written document." These definitions do not take into consideration the progress the state has made toward administrative simplification, which has included the move toward electronic submissions of information such as eligibility and claims. To require a referral or a care plan to be a written document is the same as requiring they be a paper document as there is not a definition in either state statute or rule that allows a written document to be electronic. Requiring paper is moving backwards and is counter to the goals of reform. Instead, the rules should specifically include within these definitions an electronic means of communication and documentation in addition to a written document. This would allow for more efficiency within the administration and care coordination duties of a certified	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	Rule definition change for care plan. We inserted "including an electronic document". According statute 645.44, subdivision 14, "written" can be "any mode" - so this includes electronic.

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				health care home. Additionally, this would better fit in with the requirement of an electronic patient registry in part 4764.0040, subpart 3. The final rules should allow for care plans referrals to be made electronically.		
16	7			Question: will chromosomal variations such as Down syndrome qualify as a "chronic condition" under your plan?	The Down Syndrome Association of Minnesota, Kathryn L. Nelson	Yes. We will address this through training.
17	7			Will chronic pain be considered one of the conditions? [Many of our state covered patients have this as their main diagnosis.]	SuperiorHealth Lakewalk, Carol Farchmin, MD	Yes. We will address this through training.
18	8			<u>Definition of Clinics:</u> The inclusion of a definition for "clinics" is an important addition to the rules. However, will MDH interpret "clinic" to include a mental health center? It is not clear to what extent the health care home designation could be applied to community mental health centers. The most appropriate model for a "health care home" for a particular person with a mental illness (chronic condition) with attending physical problems might be a mental health center with primary care built into the team with the presence of a physician, physician's assistant, or nurse practitioner. Similarly, "complex condition" is defined as one or more <i>medical</i> conditions; will "medical" be interpreted to include mental illnesses and other cognitive conditions? Some systems of care include mental in the word "medical"—but some do not. The rule needs to be clear on whether mental health conditions will be served under the health care home model. As written, the expedited rule does not make this at all clear.	Minnesota Disability Law Center, Jennifer E. Giesen	Mental health is noted in the definition of complex condition. This definition includes the broad scope of diagnoses. The requirements for participation are referenced in 0020, subp 30 "primary care" which means overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions including end of life care when appropriate. This will be addressed through training.
19	8			Clarify whether "clinic" includes community mental health centers.	See DHS licensing provisions—Rule 29	A mental health center can be a "clinic" if it qualifies as an eligible provider as defined in 0020 subp.15 , "Eligible provider" means a personal clinician, local trade area clinician or clinic that provides primary care services and provides the full scope of services as outlined in 4764.0020 Subp. 30 the definition of primary care. This will be addressed through training.
20	8			Clinic now defined - good	Courage Center, Jan Malcolm/John Tschida	No change.
21	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	Minnesota Hospital Association, Matthew L. Anderson, JD	No change. The 2008 health reform legislation authorized the development of health care homes for those patients with complex and chronic conditions. Because individuals will benefit differently from health care homes, the legislation did not specifically define complex or

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				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.		chronic conditions. This is in order to provide maximum flexibility to identify those patients who would most benefit from coordination of care to achieve the best health outcomes for those individuals.
22	11			Specify whether mental health conditions are included in the term "complex condition."	Minnesota Disability Law Center, Jennifer E. Giesen	The requirements for participation are written broadly enough. See 0020, subp 30 "primary care," which means overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions including end of life care when appropriate. This will be addressed through training.
23	11			Useless definition - will not provide clarity to any system considering developing a medical home or for the state in evaluating their success.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	No change. The 2008 health reform legislation authorized the development of health care homes for those patients with complex and chronic conditions. Because individuals will benefit differently from health care homes, the legislation did not specifically define complex or chronic conditions. This is in order to provide maximum flexibility to identify those patients who would most benefit from coordination of care to achieve the best health outcomes for those individuals.
24	11			Complex now means one or more -- good	Courage Center, Jan Malcolm/John Tschida	No change.
25	12			Complications may occur due to adding external care plans, for instance, HIPPA compliance, reluctance to exchange proprietary information between different health care systems and difficulties in incorporating materials into an electronic record.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Providers must comply with applicable privacy and confidentiality laws, including HIPAA. See 0040, subp 1F. In 0040, Subp 1F, any resulting actions from the health care home must establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws, including the requirements of the Health Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13.

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26	13			What level of access does that imply? Access to providers or to emergency care that will be communication to the primary care provider? It is unreasonable to assume that a clinic would be able to offer 24/7 patient access to staff and patient's medical records.	Northstar Physicians Network, Bruce Penner, RN	Improving cost and quality is as essential for small rural clinic patients as for others. Systems need to be in place to address emergency situations, and the patients notified of those the same as other populations. Sample variances will be catalogued and available.
27	14			The definition does not identify consistent, reliable and administratively-simple ways a clinic would be able to measure cost-effectiveness. Please see further discussion under 0040.9.B.3.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	No change. The Community Outcomes Measurement Advisory Committee will address this issue and provide recommendations and guidance to clinics.
28	14			Clarification is needed to ensure that evaluations on cost-effectiveness are not used to discriminate against those with a perceived lower quality of life. Recommend adding to the definition, "This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life."	Minnesota Citizens Concerned for Life, Andrea Rau, Legislative Associate	This definition does not supersede and is consistent with the definition in Statute 62U.02 Subp 5. A requirement to measure cost-effectiveness does not affect the ethical care delivery for patients.
29	15			Would like the definition of "Eligible Provider" to include only those with a specialty of Family Practice, Internal Medicine and Pediatrics. We feel that only these traditional primary care specialties can meet the certification standards of "being responsible for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions, including end of life care".	St. Mary's Duluth Clinic Health System, Thomas G. Patnoe, MD, President/ Chief Medical Officer	The term "eligible provider" in 4764.0020 Subp. 15 is defined and the criteria is in the standard and definition. The purpose focuses on the standard.
30	15			"local trade area clinician" is a weak substitute for primary care provider for such a needy and complicated group of patients. This is in both 15 and 23.	Lakewood Health System, John Halfen, MD	No change
31	16			Recommend including the word "cultural" to the list of needs	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	Rule change to add "cultural" after spiritual in definition. See 256B.0751, Subd 2 (a) (3)...and providing care that is appropriate to the patient's race, ethnicity, and language.
32	16			I would encourage the MDH to help organize/promote palliative care training for Minnesota primary care providers. By the nature of what we do we are involved in "End of life care" yet many of us feel we could learn new skills that would help us be more effective in meeting Pt's. needs.	SuperiorHealth Lakewalk, Carol Farchmin, MD	End-of-life care will be addressed in training. Additional training/resources regarding this issue will be taken into consideration.
33	17			Delete expert consensus. We can't use valuable and already too short time and effort on unproven cares. Primary care office studies have shown that following even well documented recommendations already would take more time than exists.	Monticello Clinic, Glenn Nemeck, MD	Rule change to remove "expert consensus" in definition.

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34	17			Definition of evidence-based guidelines refers to other authoritative sources such as "expert consensus" – which is neither explained nor defined. A vague reference may lead to confusion or dispute over what constitutes an expert consensus.	UCare, Barry Baines, MD, Chief Medical Officer	Rule change to remove "expert consensus" in definition.
35	17			We recommend strengthening the definition of "evidence-based guidelines" by eliminating "expert consensus." Expert opinion is wrong far too often to allow it to be used as a measure of good care. If we mandate an element of care, then we should know that it is appropriate, or we could be racing from one misconception to another. We have had many examples over the years. Take for example the latest example of "everybody should have an A1c as low as possible, certainly less than 7.0%", a fact firmly entrenched in "expert opinion", and even used as a measure of quality that unfortunately leads to higher death rates. "Evidence-based" should mean based in randomized controlled trials, or in research that is based on causation, not weak associations or expert opinion. Reference: <i>Strength of Recommendation Taxonomy (SORT): A patient-centered approach to grading evidence in the medical literature. Ebell MH et al. J Fam Practice 2004;53:111-120</i>	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Rule change to remove "expert consensus" in definition.
36	17			Useless definition - will not provide clarity to any system considering developing a medical home or for the state in evaluating their success.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Rule change to remove "expert consensus" in definition.
37	18			Question about other examples of who would qualify as a provider of an "external care plan". Would this include other specialty providers such as behavioral health providers?	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	Rule change to revise definition by deleting "a plan by a social worker or case manager" and adding "a case management plan, a behavioral health plan".
38	19	A	1	The term "family" can have legal implications. If I want to identify my next door neighbor as "family" under A, will all the health care professionals involved be comfortable with that? Is it clear enough under this definition that I can do that? To avoid any confusion about what is intended by "family" in this definition, we believe the definition should include "any person or persons identified by the patient as a <i>person who provides care and support</i> (as opposed to a "family member").	Minnesota Disability Law Center, Jennifer E. Giesen	The rule is the minimum standard and does not preclude other persons from providing care and support to the patient. The person is identified by the patient.
39	19	A	1,2,3 & B. 1-5	Confused by the inclusion of "a spouse" in B and not under A? Wondering if language should include the words "same sex partner" or if that is included under A.1 "any person or person identified by the patient as a family member". What about community/spiritual leaders? For some cultures, community/spiritual leaders play a major role in health care decisions and must be consulted before agreeing to treatment.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	Rule change to revise definition to include A. 4. "a spouse"

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40	19	A		It is good that it's not the legal definition of family and it's broader. Can we add wording to a.1. "any person(s) identified by the patient as a person who provides care and support." (remove "family member") as in line 4.14.	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	The rule is the minimum standard and does not preclude other persons from providing care and support to the patient. The person is identified by the patient.
41	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	First sentence is addressed with rule change. For the sentence, the definition does not affect existing law.
42	19	A		Why is "spouse" included in the definition of family for someone <i>under age 18</i> , but not for someone over age 18?	Minnesota Disability Law Center, Jennifer E. Giesen	Rule change to revise definition to include A. 4. "a spouse"
43	19	B	1	For the same reasons mentioned above, the term "family member" should be replaced with "person who provides care and support."	Minnesota Disability Law Center, Jennifer E. Giesen	The rule is the minimum standard and does not preclude other persons from providing care and support to the patient. The person is identified by the patient.
44	19	B	2	Concern that the natural and adopted parent and step parent must all live in the home with the patient (i.e. parents are divorced and dad doesn't live in the house). Should say "natural or adopted parent or parents or stepparent who live in the home with the patient" add "or".	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	Rule change. We added "a" before stepparent. In Subp. 19 B (4) we deleted "and" and inserted "or".
45	19	B	2	Subpart 19.B.2 could be read as requiring the natural or adoptive parent to live in the home with the patient, which could exclude divorced parents, for example. The definition should be clarified. One suggestion is to include appropriate commas and an "or" so that it would read as follows: the natural or adoptive parent or parents, or a stepparent who lives in the home with the patient.	Minnesota Disability Law Center, Jennifer E. Giesen	Rule change. We added "a" before stepparent. In Subp. 19 B (4) we deleted "and" and inserted "or".
46	19	B	3	Minnesota Statute section 260.325 does not exist. Was Chapter 257B, Standby Custodian, what was intended?	Minnesota Disability Law Center, Jennifer E. Giesen	Correction was made in the rule. We changed 260.325 to 260C.325.
47	19	B	4	We encourage the use of "or" as opposed to "and" in this definition so that it reads: "any adult who lives with <i>or</i> provides care and support . . ." This would allow adult siblings, grandparents, other relatives, or family friends who provide care and support but do not live with the patient to be included in the definition.	Minnesota Disability Law Center, Jennifer E. Giesen	Rule change. We deleted "and" and inserted "or".
48	19	B	5	The definitions do not appear to accommodate foster parents as designated by local human services agencies and juveniles in a court-appointed correctional setting	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President	Rule change. We deleted "and" and inserted "or".

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					and Katherine Cairns, Executive Director	
49	19	B	5	The definitions do not appear to accommodate foster parents as designated by local human services agencies and juveniles in a court-appointed correctional setting.	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	Rule change. We deleted "and" and inserted "or".
50	21			Is collaborative participation required to be in person and real-time or will on-line, phone or video conferencing options be allowed? Does a collaborative need to be approved by the state? Please expand or define "different health care organizations." Does this include different sites in the same clinic system? Would organizations include professional membership associations? Would involvement in a collaborative sponsored by a health care system or a non-profit quality improvement organization count towards this requirement?	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	According to 256B.0751, Subd 5, The commissioner shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.
51	22			Again – defining the members of the team specifically, and the outcomes desired only relatively is not congruent with the work required to move from the current state of the medical home concept to an optimized endpoint.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	According to 256B.0751, Subd 2 A.4 and A.6, the standards must provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition and Subd 2 A.6, enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators..... This rule definition allows for a team to be assembled to meet the patient's needs.
52	22			Please consider revising the membership of the Healthcare Homes teams to include behavioral health.	Children's Mental Health Services, Thomas G. Shroyer, PhD, Executive Director	Rule change. We added "and may include other health professionals based on the participant's needs" at end of the definition.
53	23			May need further clarification re: local trade area clinician	Park Nicollet Health Services, Amy Burt, DO	The definition of a local trade area clinician will be addressed in training.
54	23			The term "Local trade area" is used in several sections of the proposed rule. At SMDC we have providers in Wisconsin (Ashland, Hayward and Spooner) and we would appreciate clarification regarding if and how these providers would qualify for certification as a Health Care Home.	St. Mary's Duluth Clinic Health System, Thomas G. Patnoe, MD, President/ Chief Medical Officer	The definition of a local trade area clinician will be addressed in training.
55	24			Thank you for including patient experience in the list of outcomes as this is an important piece of health literacy	Minnesota Health Literacy Partnership,	No change recommended.

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				work, perceived understanding and shared decision making.	Alisha Ellwood, MA, LMFT	
56	24			Please add some clarifications around expected performance, benchmarking (local, national) and confidence intervals.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	No change. Clarification is provided in 4764.0030 Subp. 6 A-F. The Community Outcomes Measurement Advisory Committee will be addressing the expected performance and benchmarks.
57	24			Outcome now includes maintenance and patient experience -- good But still no reference to absence of avoidable conditions & complications, although this would probably be encompassed in the definition as revised.	Courage Center, Jan Malcolm/John Tschida	We recommend no change. In 4764.0020 Subp. 24 "outcomes"- an outcome means a measure of improvement, maintenance, or decline as it relates to patient's health status, patient experience, or measure of cost-effectiveness in a health care home. See 4764.0030, Subp. 5 B.3- the benchmarks established by the commissioner for improving the quality of services (Triple Aim) in its primary care services patient population have been achieved. Outcomes measurement will be risk-adjusted for population severity of illness and non-medical complexity.
58	26			Person centeredness must drive a medical home approach but it is not fully present in these proposed rules. (See expanded explanation in letter from Colleen Wieck).	Minnesota Governor's Council on Developmental Disabilities, Minnesota Department of Administration, Colleen Wieck	We revised the definition to: "Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices.
59	26			The term "patient and family centered" is also referenced in the standards specified under Rule 4764.0010, Subp.2; however, the proposed rules could be improved by delineating the true meaning of "patient centered" in a health care environment. (See expanded explanation in letter from Colleen Wieck).	Minnesota Governor's Council on Developmental Disabilities, Minnesota Department of Administration, Colleen Wieck	We addressed this through a rule definition change in 4764.0020, Subp. 33.
60	26			Suggest rewording section to include "understanding" – see text: "Patient and family-centered care" means planning, delivering, and evaluating of health care through shared decision-making and understanding that is based on	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	We addressed this through a rule definition change in 4764.0020, Subp. 33.
61	26			This definition is not reflective of what patient-family-	Minnesota Department of	We revised the definition to: "Patient and family-

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				centered care is. Should say, "Patient and family-centered care means planning, delivering, and evaluating health care through patient driven shared decision making that is based on participation, cooperation, trust, and respect of participant perspectives and choices".	Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices.
62	26			1. The commonly accepted definition of patient or family centered care includes a core concept of information sharing that appears to be missing in this definition. Recommendation: Insert after "choices"... "Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making".	Family Voices of Minnesota, Ceci Shapland and Board of Directors	We addressed this through a rule definition change in 4764.0020, Subp. 33.
63	26			2. The use of the term "considering" in relation to patient perspectives and choices implies that the health care home can act without regard to patient perspectives and choices so long as they have considered what those perspectives and choices might be. Recommendation: delete the term "considering" and insert "honoring", "recognizing" or "with deference to"	Family Voices of Minnesota, Ceci Shapland and Board of Directors	We revised the definition to: "Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices.
64	26			3. The term "cooperation" might imply acquiescence or "complying with". On the other hand, the term "collaboration" is defined as working together toward a common goal which I believe is the intent of this part of the definition. Recommendation: delete "cooperation" and insert "collaboration". The Institute for Family-Centered Care, What is Patient and Family-centered care? http://www.familycenteredcare.org/faq.html	Family Voices of Minnesota, Ceci Shapland and Board of Directors	No change. While this comment is noted, no other group expressed this concern. Cooperation is a key element of collaboration.
65	26			Can't make the Dr. responsible for knowing the pt's values, beliefs, and culture of all the different patients we see. Has to be the patient's responsibility to speak up if a conflict is seen. I'm trained to be a doctor, not a sociologist.	Monticello Clinic, Glenn Nemeck, MD	No change.
66	26			Definition of patient and family centered care refers to shared decision making and incorporating the participant's knowledge, values, beliefs, and cultural background. Achievement of general value goals as a condition of initial certification or recertification will be difficult to document.	UCare, Barry Baines, MD, Chief Medical Officer	Documentation of patient and family centered care will be addressed in training.
67	26			We fully endorse the following components of the rule: The definition of "Patient and Family-Centered Care" includes patient's and caregiver's knowledge, values, beliefs, and cultural background.	Minnesota Breast Cancer Coalition, Christine K. Norton	We addressed this through a rule definition change in 4764.0020, Subp. 33.
68	26			This definition does not truly reflect patient and family-centered care. The word "considering" is ambiguous. What does it really mean to "consider" something? Moreover, the health care "decision" is the patient's, not the team's, decision (as the team has no legal authority to override a	Minnesota Disability Law Center, Jennifer E. Giesen	We revised the definition to: "Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on

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				patient's decision as to the health care the patient consents to receive). Therefore, we believe this definition should read: "Patient and family-centered care means planning, delivering, and evaluating of health care through shared <i>patient-driven care-planning</i> that is based on participation, cooperation, trust, and respect of participant perspectives and choices. . . ." In other words, replace "shared decision-making" with "shared care-planning" and remove the words: "by listening to and considering."		participation, cooperation, trust, and respect of participant perspectives and choices.
69	26			The definition clearly defines "patient-centered," but it does not adequately identify the ways in which care would be "family-centered" and how that would be different for children, independent adults and adults who are not independent.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	This will be addressed in training or as part of a learning collaborative.
70	26			For what it's worth, this definition of patient and family-centered care is most often used, essentially verbatim, as an excuse by clinicians with poorer than average clinical outcomes.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	This will be addressed in training or as part of a learning collaborative.
71	27			a physician assistant registered <u>licensed</u> and practicing under as of this year we are no longer registered – we are licensed; or will be as soon as the Board of Medicine implements the new law	Bev Kimball, PA-C (individual)	Rule change in definition. We deleted "registered" and inserted "licensed".
72	27			We fully endorse the following components of the rule: The inclusion of a licensed and registered Advance Practice Nurse as a "Personal Clinician."	Minnesota Breast Cancer Coalition, Christine K. Norton	So noted.
73	27			Legislation passed in 2009 changed Minnesota Statutes, chapter 147, so that physician assistants are now licensed in Minnesota.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Rule change in definition. We deleted "registered" and inserted "licensed".
74	28			The definition of preventative care should include "treatment. We believe treatment should be included because there are preventative treatments including nicotine replacement therapy that prevent health problems	American Cancer Society - Minnesota, David F. Arons, Director of Government Relations	Rule change in definition. We inserted "treatment."
75	29			Term "medical record" is not defined. What is considered part of the "medical record"? What about the case of multiple medical records? What about information important to a patient's health, but not necessarily in a medical record (housing info, school records...)? Medical record still not defined, yet referenced in "pre-visit planning" no change.	Courage Center, Jan Malcolm/John Tschida	"Medical record" is a widely used term. It means a systematic documentation of a patient's medical history and care. We have emphasized in the rules Patient- and Family-Centered Care. MDH anticipates that through this type of care, patients will share with their primary care physician other records that have been created and disclose other important information as necessary.
76	30			The definition of "primary care" is overly broad by including "overall and ongoing medical responsibility for . . .	Minnesota Hospital	So noted. The definition is consistent with

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				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.	Association, Matthew L. Anderson, JD	national definitions of primary care.
77	30			We recommend the following definition for Primary Care – “Overall responsibility for the delivery of personalized, comprehensive, and continuous care for the patient across the spectrum of healthcare needs”. The proposed definition for primary care is beyond the normal responsibilities of the primary care physician and the intent of HCH. Joint Principles of the Patient-Centered Medical Home (AAFP, 2007)	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	The rule definition is consistent with the Joint Principles of the Patient-Centered Medical Home (AAFP, 2007)
78	31			Is it within the authority of the state of Minnesota to require that an applicant be responsible for the time and effort required to collect data on their patients “regardless of whether a patient has chosen to participate in the health care home” as stated in Subp. 31 or regardless of whether the patient is considered eligible for insurance coverage? [See further references to “primary care services patient population in 4764.0030, Subp. 5 (3) and Subp. 6, and 4764.0040. Subp. 11(B).]	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	No change. This is consistent with Statute 62U.02 and Institute for Healthcare Improvement population-based data collection.
79	32			Definition of referral—referrals are mostly done electronically and are not “written” unless the referral is for outside of the care system. This subpart is written for any services outside the HCH. Please refer to the definition for a HCH.	Hennepin County Medical Center, Craig Garrett, MD	Rule change. We added "electronic" to definition. According statute 645.44, subdivision 14, "written" can be "any mode" - so this includes electronic.
80	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Rule change. We added "electronic" to definition. According statute 645.44, subdivision 14, "written" can be "any mode" - so this includes electronic.
81	32			Language is inconsistent with current CMS guidelines regarding referral (with a transfer of care) vs. consultation.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Rule definition change. We inserted "a consultation for" evaluation...The intent of the referral is determined by the clinician.
82	33			Shared Decision-making: This definition doesn’t take into account knowledge that the family and patient bring to the visit; change to: “Shared decision-making means the mutual exchange of information between the participant and the	Minnesota Department of Health, Health Care Homes Consumer and	Rule definition change. "Shared decision-making" means the mutual exchange of information between the participant and the

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				provider to assist with understanding the risks, benefits and likely outcomes of available health care options so the patient/family or primary care giver is able to actively participate in decision making." Eliminate, "select among those health care options".	Family Council, Rebecca Schlough	provider to assist the patient with understanding the risks, benefits and likely outcomes of available health care options so the patient and family or primary care giver are able to actively participate in decision making.
83	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	New concepts in the HCH context do not change the current informed consent laws.
84	33			Shared Decision-Making "Shared decision-making" is a misnomer and legally confusing. A participant or the participant's guardian or health care agent makes an informed decision based on information and discussion with the health care team, which does not have legal responsibility or authority to make medical decisions on behalf of a participant. A better term might be "shared care-planning" with the outcome of participant "informed decision-making." (Related to this, line 16.10 refers to "advance" directives, but in Minnesota the statutory term is "health care directive," which includes end-of-life directives and, by incorporation, advance psychiatric directives.)	Minnesota Disability Law Center, Jennifer E. Giesen	New concepts in the HCH context do not change the current informed consent laws. The patient makes the final decision.
85	33			We fully endorse the following components of the rule: The inclusion and detailed definition of "shared-decision making." The Shared-Decision Making Program at Dartmouth has proven to be very effective in helping women decide on the type of breast surgery & treatment that is most appropriate for them. We encourage wide adoption of SDM.	Minnesota Breast Cancer Coalition, Christine K. Norton	No change recommended.
86	33			Use "shared care-planning" instead of "shared decision-making." "Shared decision-making" is a legally murky term as there is no authority for team members to make medical decisions on behalf of the participant unless the participant specifically has so authorized under a health care directive (which has specific prohibitions for providers, and rightly so) or has a guardian. The team members are really involved in "shared care-planning" so the participant can engage in "informed decision-making." The made up term "shared decision-making" is confusing, has no legal basis, could create conflicts of interest for providers, and is going to	Minnesota Disability Law Center, Jennifer E. Giesen	Definition change: "Shared decision-making means the mutual exchange of information between the participant and the provider to assist the patient with understanding the risks, benefits and likely outcomes of available health care options so the patient and family or primary care giver are able to actively participate in decision making. This definition responds to the

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				leave a lot of people unsure as to what their rights really are. It could be an impediment to enrollment in health care homes as well. In addition, a more accurate description of "shared care-planning" includes the mutual exchange of information, not just the provider giving information to a patient. Moreover, the patient may have ideas beyond the "health care options" presented by the provider and therefore the final phrase ("to select among those health care options") should be removed. This definition should be changed to read: "Shared <i>care-planning</i> " means <i>the mutual exchange between a participant and the provider of information . . . so that the patient is able to actively participate in care-planning.</i> "		concern.
87	33			The rule does not adequately define the term "shared decision-making." Without an adequate definition providers may be unable to differentiate between "shared decision-making" and the currently applicable informed consent requirements? The rule should require providers to adhere to the applicable informed consent requirements and should not introduce a new term.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	No change. New concepts in the HCH context do not change the current informed consent laws.
88	33			This is a wonderful addition.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	No change recommended.
89	34			Definitions: In medicine the common definition of specialist is reserved for medical doctors who engage in a medical specialty. Typically, a specialty in medicine is a branch of medical science - the result of medical doctors furthering their medical education in a specific specialty of medicine. In the definition of specialist provided in the rule, the examples are potentially confusing as they include those who are not Doctors of Medicine or Doctors of Osteopathic Medicine. We suggest omitting the examples or changing the last part of the sentence to read "such as traditional medical specialties and subspecialties, individuals with special training in mental health, nutrition, social services and other community-based resources."	Minnesota Medical Association, Robert Meiches, MD	Rule definition change. We added at the end "traditional medical specialties such as a cardiologist or osteopath. It also means individuals with special training in subspecialties such as chiropractic, mental health, nutrition, pharmacy, social services and other community-based services."
90	34			Please clarify this definition for specialists due to confusion between medical specialists and other professional specialists in the health system and/or community.	Park Nicollet Health Services, Amy Burt, DO	Rule definition change. We added at the end "traditional medical specialties such as a cardiologist or osteopath. It also means individuals with special training in subspecialties such as chiropractic, mental health, nutrition, pharmacy, social services and other community-based services."
91	34			In the definition of specialist, the examples seem random and potentially confusing. We suggest omitting the	Minnesota Academy of	Rule definition change. We added at the end

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				examples or changing the last part of the sentence to read "such as traditional medical specialties and subspecialties, individuals with special training in mental health, nutrition, social services and other community-based resources."	Family Physicians, Patricia Fontaine, MD, MS, President	"traditional medical specialties such as a cardiologist or osteopath. It also means individuals with special training in subspecialties such as chiropractic, mental health, nutrition, pharmacy, social services and other community-based services."
92	36			Same as in draft rule. No further clarification in the definitions section. Will state-wide reporting system encompass the outcomes for what could be a breadth of populations who would benefit from a health care home (measures for complex pediatric, oncology, cardiac, limited English speaking, disabled...)?	Courage Center, Jan Malcolm/John Tschida	The Community Outcomes Measurement Advisory Committee will address this issue.
93	36			It is critical that only statistically valid data be used to measure and publically report the quality of care. Internally derived data in small sets can be a successful QI tool but is not acceptable when reporting the quality of the entities referenced by the data. The process by which the data is collected, analyzed and reported must have the same provable high standard as the providers whose reputations will be affected by the data.	Northstar Physicians Network, Bruce Penner, RN	It is reflected in the standard.

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94				A notion of quality is presented in Rule 4764.0030, the Rule that outlines certification and recertification procedures for eligible providers or clinics. What is most troubling is that certification and recertification is based on a self assessment, giving a provider or clinic full authority to evaluate itself and describe how it meets certain requirements.	Minnesota Governor's Council on Developmental Disabilities, Minnesota Department of Administration, Colleen Wieck	No change. Each clinic will also have a site visit as referenced in 4764.0030, Subp.3 "onsite review and additional documentation". Also, 4764.0030 Subp.2 Contents of the application A,B,C- will be submitted and reviewed.
95	1			What impresses me about the rules relates to certification and re-certification. Given the letter of intent, the timing of the recertification (yearly), awaiting DHS responses, appeals, it appears that significant resources and time will be spent in providing in depth information to the STATE. Feedback for subp 1-7	Hennepin County Medical Center, Craig Garrett, MD	See MN Statute 256B.0751 Subd 3: in order to maintain their status as health care homes, clinicians or clinic must renew their certification annually.
96	1	A		If a provider leaves a certified clinic, does a new provider in the clinic have to become certified before the whole clinic is once again certified?	Hennepin County Medical Center, Craig Garrett, MD	Rule change. 4764.0030 Subp. 1 B. It is the clinic's responsibility to notify the department when a new clinician joins a certified clinic and intends to become a certified clinician. The clinic has 90 days from date of hiring the new clinician or until its next annual anniversary date to apply

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						for recertification, whichever is sooner. A clinic may operate as a certified clinic with the new clinician acting as though certified until the new clinician is certified. If the clinician chooses not to be certified, the clinic will no longer be certified; but the clinicians who were previously certified as part of the clinic will automatically hold an individual certification only.
97	1	A		The rule should specify whether there is an application fee for certification or recertification? If a fee is applicable, the fee amount should be established prospectively. In addition the rule should: 1) Establish a deadline for application submission or specify that no deadline is applicable; 2) Clarify that the certification and recertification may be submitted electronically; 3) Clarify that existing credentialing data and enrollment processes will be utilized; and 4) Clarify that DHS, and not the health plans, will be responsible for assisting HCH clinics in the certification and re-certification process.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	MDH will provide assistance with administrative details of the certification and recertification process through training and individually if needed. MDH does not have legislative authority to charge a fee. This will also be covered in the Certification Guide.
98	1	A		Suggest that "care team" be clarified or included in the definitions with a description to be consistent with the definitions in rules section 4764.0020	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President and Katherine Cairns, Executive Director	The definition of care team can be found at 4764.0020 Subp. 22 "health care home team or care team".
99	1	A		Suggest that "care team" be clarified or included in the definitions with a description to be consistent with the definitions in rules section 4764.0020	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	The definition of care team can be found at 4764.0020 Subp. 22 "health care home team or care team".
100	1	B		A clinic may not be certified unless <u>all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in health care homes.</u> It appears that it is the "clinic" entity, acting as the applicant that has to attest to meeting the HCH standards. Not clear how a clinic applicant will be able to demonstrate/attest that all individual clinicians/practitioners meet the HCH standards. For example, one HCH standard is that the applicant must establish a system designed to ensure that participants are informed that they have continuous access to designated staff; an on-call provider; or a provider triage system. How will the "clinic applicant" document that each individual participating clinician affiliated with the "clinic applicant" meets this standard?	UCare, Barry Baines, MD, Chief Medical Officer	Rule wording change to match legislation: A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home. This will be addressed in training. See 4764.0030 Subp 2, Subp 3 and Subp 5 B.2.

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101	1	B		If providers become certified over time such that all providers become certified, does the clinic itself have to become certified? At what point does there become just one certification and re-certification process.	Hennepin County Medical Center, Craig Garrett, MD	This will be addressed in training. It is an administrative process. The department will have an internal procedure for adjusting the anniversary date as needed. The timeline will be adjusted for the convenience of the clinic and the State.
102	1	B		It is confusing to start with the negative and then say unless. Suggestion to change wording to: "All of the clinic's personal clinicians and local trade area clinicians must meet the requirements for participation in the health care home for a clinic to be certified."	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	Rule change to match legislation: A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home.
103	1	B		All of a clinic's clinicians unlikely to satisfy requirements or even attempt to do so as may be doing Urgent Care, etc	Lakewood Health System, John Halfen, MD	This will be addressed in training. See definition of primary care in 4764.0020 Subp. 30 "primary care".
104	1	B		Why do all of the clinic's personal clinicians have to meet requirements for participation, particularly if a number of the clinic's patients do not want to participate in the health care home model? If a mental health center wanted to offer the health care home model as an option for its patients, would it make sense to require all clinicians to participate? Is this requirement going to act as a disincentive for clinics to try this model of care?	Minnesota Disability Law Center, Jennifer E. Giesen	This will be addressed in training. See 256B.0751, Subd. 3 A, "a personal clinician or a clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home..."
105	1	B		The draft rule contains a provision requiring clinic certification and requiring that all physicians in a clinic must meet the requirements for participation in the HCH. This requirement is unworkable for any multi-specialty practice because not all specialists are appropriate for managing primary care services through HCH. Certification should be limited to only those clinicians who will be providing services to HCH patients. We believe it is better to focus resources to improve patient care, and we believe certifying both the clinic and the physicians will add administrative cost without the benefit of improving patient care.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	This will be addressed in training. See 256B.0751, Subd 3 A. Requirements for clinicians certified as health care homes and 4764.0020 Subp 30 "primary care services".
106	1	B		Unchanged from draft. Same concern (above) as in draft: It will likely be impossible for an entire "clinic" to remain certified for any length of time given the normal addition and attrition of clinicians over the course of the year. How will a certified clinician who changes clinics during the course of the year be evaluated? Based on the participants enrolled with that clinician over the course for the year regardless of the clinic or health care home within which that clinician is practicing?	Courage Center, Jan Malcolm/John Tschida	Rule Change. We renamed 4764.0030, Subp 1. Who may apply to Eligibility for certification. A detailed change for Subp. 1 B is in the revised rules.
107	1	B		How does this impact health plan contracting and reimbursement which is calculated at the clinic-level? It would seem more logical to have a clinic be the HCH	Northstar Physicians Network, Bruce Penner,	This is required by 256B.0751, Subd. 3 Requirements for clinicians certified as health

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				certified entity with either the requirement for all providers working at the clinic to agree to these standards or have individual providers excluded from the HCH "contract." The exclusion of specific providers from certain contracts already exists in some instances so there is precedent for that model.	RN	care homes. Provider clinic contracts will likely address this as noted.
108	2	A	7.22	CCCH strongly believes that that self-assessment needs to have a portion which assesses the cultural competence of the organization. CCCH has such a tool, or there are others available.	Center for Cross-cultural Health, Sandra Eliason	MDH appreciates the comment but notes the rule has provisions to satisfy the statutory requirements. This proposal is an aspiration for the future perhaps but not part of this certification standard.
109	2	C		Unchanged from draft. Same concern (above) as in draft: Overly broad. Need to further define or limit what the Commissioner can require of an applicant.	Courage Center, Jan Malcolm/John Tschida	No change. This will be addressed in training. The commissioner has the legislative authority to determine what meets the criteria for certification. Certification is voluntary, a clinician or clinic can withdraw at any time.
110	3	B	2	The rule should specify to whom the report should be issued and/or provided, if the reports are required, or if they are to be for internal use only. This provision will increase costs and administrative burdens for providers.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	Report use will be addressed in training. The report is for internal use.
111	3			Is the commissioner the one that has to go out and conduct the site-review? This language, infers that is the case. Suggestion to change wording to " The commissioner may require an on-site review". Changing the wording may allow for more flexibility in who conducts the review.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	No change. This will be addressed through training. The Commissioner has the authority to delegate responsibilities.
112	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	No change. This will be addressed in training. The discretion is appropriately limited to information needed for certification.
113	3			The rule needs to clarify the circumstances under which the commissioner could conduct an on-site review and request additional documentation. Such circumstances should be limited to those matters that are relevant to HCH certification.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	No change. This will be addressed in training. The discretion is appropriately limited to information needed for certification.
114	3			Unchanged, however, clinic is now defined, so is it to be	Courage Center, Jan	No change. This will be addressed in training.

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				assumed that the certified clinic would be the location of the "site"?	Malcolm/John Tschida	
115	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	The applicant and the evaluators will communicate with each other. See 4764.0030 Subp. 4 "An application for certification or recertification is complete when the commissioner has received all information in Subp. 2; the onsite review, if any, has been completed; and the commissioner has received any additional documentation requested under Subp. 3.
116	4			The rule must specify when a completed application is submitted so providers can plan appropriately.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	The applicant and the evaluators will communicate with each other. See 4764.0030 Subp. 4 "An application for certification or recertification is complete when the commissioner has received all information in Subp. 2; the onsite review, if any, has been completed; and the commissioner has received any additional documentation requested under Subp. 3.
117	5			It is also unclear if there are two of five providers in a clinic who are certified and each was certified at a different time, what is the timing of the re-certification process. It seems impossible to have several different time frames for re-certification occurring throughout the year.	Hennepin County Medical Center, Craig Garrett, MD	The State will adjust certification timelines to the mutual benefit of both parties to one certification anniversary date. This will be addressed in training and the training and certification guidelines.
118	5			The yearly time frame for recertification with the requirement of proving effectiveness is far too short to be reasonable for a number of conditions, especially in pediatrics. For example, patients with a history of extreme prematurity and significant complications is one group that need several years of care to show improvements over "standard care" – care that has not been coordinated.	Children's Physician Network, Peter J. Dehnel, MD	No change. See 256B.0751, Subd 3 Requirements for clinicians certified as health care homes. "Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually."
119	5			The current structure should be ok, but once a year may be too burdensome down the road to keep certified, not sure, but may need to be open to re-eval the length of time for certification. Thanks for the work and the ability to input.	NorthPoint Health and Wellness Center, Paul Erickson, MD	No change. See 256B.0751, Subd 3 Requirements for clinicians certified as health care homes. "Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually."
120	5			The proposed rule would require health care homes to get	Minnesota Hospital	No change. See 256B.0751, Subd 3

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				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.	Association, Matthew L. Anderson, JD	Requirements for clinicians certified as health care homes. "Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually."
121	5			How to seek recertification: *Also refer to Page 10: 10.1: A. Commissioner must notify.... What happens in the 30 day interim period between when their certification ends and they are waiting to find out from commissioner if they are recertified...can they bill services? There is a 30 day lag period where a clinic won't know if they are certified or not	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	No change. This will be addressed through training. There is no 30-day lag period. The clinic retains certification until formally notified by MDH of 4764.0030 Subp 7 C.
122	5			HCH recertification should be extended to 3 years to reduce administrative costs, administrative burden and disruptions to patient care.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	No change. See 256B.0751, Subd. 3 Requirements for clinicians certified as health care homes. "Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually."
123	5			Same issue in proposed rule as in draft (above). Must not be a concern for MDH- Recertification needs to be submitted no later than 60 days before anniversary date. In 0030. Sub 7, A, the commissioner has 90 days to notify about recertification. What happens during the 30 days after the anniversary date but before the commissioner notifies the clinician? Does the clinician remain certified until they hear otherwise from the Commissioner?	Courage Center, Jan Malcolm/John Tschida	The certification is from the clinic's anniversary date. There is no 30-day lag period. The clinic retains certification until formally notified by MDH of 4764.0030 Subp 7 C.
124	5	B		Small practices with smaller numbers of patients can have random fluctuations in results that would confound measuring progress to goals. Longer time periods likely necessary to even those out and see real change/no change.	Monticello Clinic, Glenn Nemec, MD	The Outcomes Measurement Advisory Committee will recommend annual benchmarks and taking the small practices into consideration. This might be a case for a variance.
125	5	B	3	Modified in proposed rule to indicate the HCH must meet established benchmarks -- better. How is "sufficient progress" defined? Who determines sufficiency? Is progress measured against the individual clinician or the "clinic"?	Courage Center, Jan Malcolm/John Tschida	No change. The Community Outcomes Measurement Advisory Committee will address this issue.
126	6	A, B		If you truly want to improve outcomes then start by having the courage to define what success is on an objective scale (using state, regional or national benchmarks). This is the one area of the proposed rule that should be rigidly defined, it is not.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	The rule provides for the benchmarks that the writer seeks in the future. The Community Outcomes Measurement Advisory Committee will address this issue.
127	6	A, E		It is unclear, but the benchmarks sound like they will be specific to a given clinic, rather than statewide. If so, the process will be adaptable to clinics with a high proportion of disadvantaged patients. But if the benchmarks are	Minnesota Association of Community Health Centers, Rhonda	The Community Outcomes Measurement Advisory Committee will address the risk adjustment methods and when appropriate to

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				statewide, we recommend there be a benchmark of aggregated data over similar clinics (not all clinics) with which the applicant's data will be compared. Clinics that see a disproportionate share of disadvantaged patients should be a separate benchmark grouping. The options (A-E) for evaluating current performance seem appropriately varied.	Degelau, Executive Director	use them.
128	6			The commissioner must use benchmarks announced annually to determine whether an applicant has demonstrated achievement of benchmarks in primary care services to its patient population. The benchmarks must be based on one or more of the following factors... and then goes on to list six possible factors. The language "one or more" could be problematic/burdensome for many clinics if the commissioner decided to use a combination of multiple factors or all six factors.	UCare, Barry Baines, MD, Chief Medical Officer	No change. The Community Outcomes Measurement Advisory Committee will address the factors for benchmarks.
129	6			The rule should clarify that annually announced benchmarks are for prospective use only and cannot be used to assess previous performance for recertification. HCH providers should be notified in advance which benchmarks will be used for evaluation purposes.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	No change. The rule already reflects this. The rule requires the benchmarks to be announced annually.
130	6			Must achieve established benchmarks -- better.	Courage Center, Jan Malcolm/John Tschida	No change recommended.
131	6			This could quickly, and even initially, become oppressive and counterproductive. Setting mandatory benchmarks for recertification within the realm of patient outcomes is: 1) Giving undue power to the entity setting the benchmark; in this case the commissioner. 2) Potentiating the alienation of some providers by setting targets that have been reached by some and are being reached for by others, but yet unattained by many. 3) Eliminating some providers from the HCH process and thus creating patient access and continuity-of-care issues because of a lack of resources to collect and report data, let alone the ability develop QI programs robust enough to achieve adequate improvement in the time that may be allotted. 4) Creating a false impression of quality or the lack thereof by virtue of a flawed data collection and reporting process that does not have repeatable and provable validity.	Northstar Physicians Network, Bruce Penner, RN	Appropriate benchmarks and data collection processes, and validation points are important. The commissioner has appointed a Community Outcomes Measurement Advisory Committee to make benchmark recommendations.
132	6			Measurement and reporting of the quality of care is unquestionable important. But what is measured, how it is measured and how it is reported as well as what goals or benchmarks are set and the resulting rewards or consequences for the achievement of those benchmarks must be more carefully defined by the medical community itself and not a governmental entity. The best and perhaps only sustainable improvement will come from within and not from mandates imposed from outside of the medical	Northstar Physicians Network, Bruce Penner, RN	Appropriate benchmarks are important. The commissioner has appointed a Community Outcomes Measurement Advisory Committee to make benchmark recommendations.

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				provider community.		
133	6	A		Same language in proposed as in draft -- no change- Improvement may be difficult if participants are already engaged, high performing complex patients/families. Maybe add in "lack of a decline"?	Courage Center, Jan Malcolm/John Tschida	No change. This is addressed in the definition of outcomes measurement.
134	6	B		Same language in proposed as in draft -- no change- Will health care homes be comparable? Will they be enrolling similar populations? Will MDH be decertifying the lowest performers? If not, why compare?	Courage Center, Jan Malcolm/John Tschida	These issues will be addressed in training.
135	7	A		If an applicant submits for recertification 60 days before the one year anniversary date but the Commissioner does not notify the applicant whether recertification is granted for 90 days (in other words, 30 days after the one anniversary date), can the health care home bill for services during that 30 day period? If the health care home is not recertified and payments in that 30 day period are denied, could the health care home seek to collect payment from the patient for a non-covered service? A provision should be added to this section that allows certification to continue pending written notification from the Commissioner.	Minnesota Disability Law Center, Jennifer E. Giesen	This will be addressed in training. The State will work with applicants to ensure the applicants comply with 4764.0030 Subp 5 so that the applicants remain certified.
136	7	B		And at part 4764.0030, subpart 7, paragraph B, the proposed rules state that "if the commissioner certifies or recertifies the applicant as a health care home, the health care home is eligible for per-person care coordination payments under the care coordination payment system." There are no other parameters in these proposed rules requiring the certified health care home to perform any care coordination services for a particular patient in order to be eligible for the care coordination payment. While this payment system has yet to be developed, and it may be clearer once that is complete, the health care home final rules should also make it clear that there needs to be more done than merely becoming a certified health care home in order to be eligible for a per-person care coordination fee. Instead, the certified health care home should also be required to perform care coordination services for that particular enrolled patient for a specified time period (such as monthly if the care coordination payment is based on a monthly time period) in order to be eligible for that care coordination payment for that particular time period.	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	The enabling statute calls for the care coordination payment to be determined separately. The payment methodology is under design. Enrollment and payment processes for care coordination workflows will address this detail.
137	7	C		The rule should clarify whether a denied applicant for certification or recertification may reapply without appealing the denial.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	Yes, the applicant may apply based on a remedy of the unmet standards. See 4764.0060 Subp. 2 A and B. The applicant may appeal by submitting either item A or B.
138	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	Minnesota Hospital Association, Matthew L.	Yes, the applicant may apply based on a remedy of the unmet standards. See

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				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.	Anderson, JD	4764.0060 Subp. 2 A and B. The applicant may appeal by submitting either item A or B.

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139				These requirements, set out under Rule 4764.0040, might be met with little or no contact with the person receiving health care services -- the person's contact information; diagnosis, allergies, medications; cultural background; protocol for scheduling an appointment within one business day; who has access to the person's medical records, etc. The requirements may be somewhat relevant to quality but some of the requirements bring into question data practices issues.	Minnesota Governor's Council on Developmental Disabilities, Minnesota Department of Administration, Colleen Wieck	See 0040 Subp 1 F establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws, including the requirements of the Health Insurance Portability and Accountability Act, title 45, parts 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13.
140	1			Again, clarification needed--is a mental illness a complex or chronic condition that makes one eligible to participate in the health care home? The continuous access language is good.	Minnesota Disability Law Center, Jennifer E. Giesen	To be addressed through training. A mental health center can be a "clinic" if it qualifies as an eligible provider as defined in 0020 subp.15 - means a personal clinician, local trade area clinician or clinic that provides primary care services.
141	1			Perhaps should require clinics certified as HCH to establish a communication among the clinic providers to encourage utilization and refinement of the HCH	Lakewood Health System, John Halfen, MD	We agree. Communication is essential and this will be added to training.
142	1			Please define <u>actively recruit</u> especially since HCH is for the patient with chronic or complex conditions. Is this using brochures, website, and letters to potential participants. Can/or should organizations actively recruit all patients into a HCH? Is this more patient education about HCH and the organization? ..patient education and choice.	Park Nicollet Health Services, Amy Burt, DO	Rule change. We revised 4764.0040 Subp 1. The applicant for certification must have a system in place to support communication among the members of the health care home team, the participant and other providers.
143	1			The word "eligible" should be added before "patients' in this phrase: ". . . must have a system in place to actively recruit the applicant's patients into the health care home . . ." and that eligibility should be defined so that clinics are not required to expend resources recruiting patients for whom they would not receive per-person care coordination payments.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	See 256B.0751, Subd 3B: ... must offer their health care home services to all their patients with chronic or complex health conditions who are interested in participating" . The departments of MDH and DHS will take these into consideration in developing the payment methodology that is currently underway.
144	1			What if a provider's "panel" is full and it is felt that adding patients will compromise access/continuity? Will patients automatically be assigned to the provider of their choice or will there be set "quota" per provider? I would encourage a risk stratification for patients with chronic diseases.	SuperiorHealth Lakewalk, Carol Farchmin, MD	See 256B.0751, Subd 3B: ... must offer their health care home services to all <u>their</u> patients with chronic or complex health conditions who are interested in participating".

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145	1			The rule should better define the term “actively recruit” with respect to patients. Objective standards, including documentation requirements, should be established in advance.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	We deleted actively recruit from the rule. However, see 256B.0751, subd 3B: ... must offer their health care home services to all their patients with chronic or complex health conditions who are interested in participating".
146	1	A	1	It is unclear what metrics will be applied to the per-person care coordination payments. States that the certified health care home must offer their services to those patients who either “have or are at risk of developing complex or chronic conditions,” which is a very broad reach.	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	The payment methodology is still being developed.
147	1	A	1	The rules state that HCH should be made available to patients who (a) have or <i>are at risk</i> of developing complex or chronic conditions. Because the ‘ <i>are at risk</i> ’ group of patients would not meet the minimum threshold for participation in HCH, the rule should clarify what reimbursement level would apply to those patients. This part of the draft rule is a good example of why the health plans should not be responsible for identification of patients.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	The payment methodology is still being developed. We agree that the clinicians and clinics should be responsible for the identification of patients. Not all patients have health plan coverage.
148	1	A	1	Useless definition - will not provide clarity to any system considering developing a medical home or for the state in evaluating their success. I believe we are all at risk of developing a complex medical condition. Reinforces the point yet again – please have clarity around the standards.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	See 256B.0751 Subd. 2(a)(7) ..focus initially on patients who have or are at risk of developing chronic health conditions.
149	1	A	1	unchanged - Who determines “active recruitment” or “effective communication”. If MDH, do they have standards to decide active or effective?	Courage Center, Jan Malcolm/John Tschida	Rule change. We deleted "active recruitment" and "effective". The standard in 0040 Subp 1 describes the requirements.
150	1	A	3	Remove A.3, Seems out of order, how would you know if they were interested if it hasn't been offered, or does this mean that they have discussed it and the patient is not interested?	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	See 256B.0751 Subd. 3(b) ...must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.
151	1	A	3	Unchanged -- problem not addressed - What happens in the case where a patient is interested in the certified clinician, but the clinician cannot realistically take any more patients. Can certified clinicians turn anyone away?	Courage Center, Jan Malcolm/John Tschida	See 256B.0751 Subd. 3(b) ...must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.
152	1	A		The change to require the applicant “to offer” health care home services is good.	Minnesota Disability Law Center, Jennifer E. Giesen	No change recommended.
153	1	A		Nice definition including especially “can benefit” and “are interested”; this makes the system workable	Lakewood Health System, John Halfen, MD	Rule change. We deleted 0040 Subp. 1 A (2).
154	1	A		A clinic may have to phase the model in over time, so it would be helpful if a clinic could establish a plan as part of initial certification to achieve this standard over a number of	Minnesota Association of Community Health	See 256B.0751, Subd 3(a):...In order to be certified as a health care home, a clinician or

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				years, rather than have to offer health care home to all patients at the outset.	Centers, Rhonda Degelau, Executive Director	clinic must meet the standards set by the commissioners in accordance with this section.....
155	1	A		The wording would require us to offer health care home services to almost all our patients, whether their insurance coverage includes this benefit or not. We would like the <u>option</u> of only enrolling patients that are covered under a health plan that would reimburse us a health care home/care coordination fee.	St. Mary's Duluth Clinic Health System, Thomas G. Patnoe, MD, President/ Chief Medical Officer	See 256B.0751, Subd 3(b): ... must offer their health care home services to all their patients with chronic or complex health conditions who are interested in participation.
156	1	A		The rule is not clear if all patients within the provider's primary care population must become members of the HCH or just certain ones. You will recall that this is a voluntary enrollment into a HCH, so not all members can or will or should be members.	Hennepin County Medical Center, Craig Garrett, MD	See 256B.0751, Subd 3(b): ... must offer their health care home services to all their patients with chronic or complex health conditions who are interested in participation.
157	1	B	1	The rules state that there must be continuous access to designated clinic staff, an on-call provider or a phone triage system. The rules define "continuous" as twenty-four hours per day, seven days per week, 365 days per year. Once more, the MMA raises concerns about the ability for some small or rural practices to offer 24/7 access and whether there may be pockets of limited medical home access due to this criterion for initial certification. A specific variance should be defined for clinics that are too small to be able to meet the access standard. This would save precious time for those clinics, rather than expect each of them to complete a complicated variance application process.	Minnesota Medical Association, Robert Meiches, MD	Improving cost and quality is as essential for small rural clinic patients as for others. Systems need to be in place to address emergency situations, and the patients notified of those the same as other populations. Sample variances will be catalogued and available.
159	1	B	2	On lines 11.1-11.12, Does continuous access to medical records by an on-call provider mean remote access to the patient's medical records, implying that an electronic medical record is required?	UCare, Barry Baines, MD, Chief Medical Officer	The clinic should determine the method to access medical information.
160	1	B	2	Does continuous mean 24/7/365? Not possible unless call person has that kind of access to the EMR. Another small practice problem that will prevent them from even trying.	Monticello Clinic, Glenn Nemec, MD	The clinic should determine the method to access medical information.
161	1	B	1,2	Some clinics in the rural areas of the state are not near a hospital and/or do not have access to after-hours answering services. Those clinics would not be able to meet this requirement. Patients in these areas would still benefit by a modified form of health care home and the clinic would still need reimbursement to help cover the expense. We recommend some alternative to this standard whereby a participant may be the "keeper" of a personal health record that would be available to emergency and hospital personnel unconnected to the clinic. This possibly could be handled via the variance procedure, but having no mention of it here might preclude a clinic attempting certification.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	The clinic should determine the method to access medical information.
162	1	B	1,2,3	As a rural resident, should not the "on-call provider" services be Toll-free? Continuous? Able to connect to an actual trained medical care provider? Define the level of service:	Seven County Senior Federation, Lisa A. Krahn	HCH statute does not alter other obligations under the law.

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				How long would a caller be on hold?		
163	1	B	2a-d	The current draft of the rules states that the health care home must insure that designated clinic staff, on-call provider or phone triage system representative has continuous access to participants' medical record information, including contact information, the patient's primary care provider's name and contact information, and the patient's designated enrollment in a health care home; racial or ethnic background, primary language, and preferred means of communication, consents and restrictions regarding the release of medical information, including release of information to specific family members; and diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant. We continue to believe that 24/7/365 access to the elements identified in this provision will be a barrier to implementation of health care homes. We strongly support modification of this criterion such that health care homes be required to "demonstrate <u>progress</u> toward" 24/7/365 access, rather than having immediate access included for initial certification. The inclusion of the phrase "medical record information" further confounds this provision as it indirectly implies broad electronic health record access, yet current electronic health records are highly variable in terms of their capacity to allow broad, secure, remote access as would be required under this provision. Practices without EHRs are even more limited in their ability to have the necessary information available to all on-call or triage providers on a 24/7/365 basis. This may unintentionally restrict the number of practices who will be able to implement health care homes. Further, the MMA suspects that the data elements described as "medical record information" may not be the right information to have available for after-hours care and questions whether these elements will facilitate quality care by on call providers. The MMA contends that the care plan, a patient-specific "road map," would be more relevant for on-call providers.	Minnesota Medical Association, Robert Meiches, MD	Refer to Minnesota State Health Plan rules: Primary Care services shall be available and accessible 24 hours per day, seven days per week within the health maintenance organization's service area. The health maintenance organization shall fulfill this requirement through written standards for: (a) regularly scheduled appointments during normal business hours (b) after hours clinics (c) use of a 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation (d) back-up coverage by another participating primary care physician and (e) Referrals to urgent care centers, where available and to hospital emergency care. NCQA: Yes, 24 hour responsibility CMS PCPCC: Yes 24 hour responsibility DHS PCC: Yes 24 hour responsibility
164	1	B	2a-d	It will be difficult to modify our current EMR system to include the mandatory data elements of: enrollment, preferred mode of communication and primary language	Park Nicollet Health Services, Amy Burt, DO	See 256B.0751, Subd 2(a)(3): ... must encourage patient-centered care,,,,,and providing care that is appropriate to the patient's race, ethnicity, and language."
165	1	B	2b	YES!	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	No change recommended.
166	1	B	2c	Line 11.10 should read "release of information to specific	Minnesota Disability Law	Rule change for 0040 Subp. 1 B(2)(c) to "the

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				family members or to others as permitted by the participant.” State and federal data release provisions do not limit permission to release information to family members only. The rule language is narrower than current legal requirements.	Center, Jennifer E. Giesen	participant's consents and restrictions for releasing medical information;”
167	1	B	3b	What obligation will participating patients have to work through their Health Care Home versus presenting to Urgent Care or an Emergency Room? Will the Urgent Care Centers and ERs be authorized to re-direct patients to their Health Care Homes before initiating care? If a patient presents for care apart from the Health Care Home, how will that facility be reimbursed for the care?	SuperiorHealth Lakewalk, Carol Farchmin, MD	This will be addressed in training and clinics need to address in operations.
168	1	B		A specific variance should be defined for clinics that are too small to be able to meet the access standard. This would save precious time for those clinics, rather than expect each of them to complete a complicated variance application process.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Clinics may submit a variance. See 4764.0050 Variance in the rules.
169	1	B	3	This language should reflect the possibility that a patient requesting an appointment may need to be sent directly to a hospital or emergency room, not just focusing on “unnecessary” care.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	The rule does not preclude necessary emergency room visits.
170	1	C	2 a b line 11.2	Once again, the HOW of this standard is important. CCCH believes that health equity cannot be achieved until accurate race and ethnicity data is collected. However, if patients agree to supply data on their race and ethnicity, the information ultimately needs to be shared with the community as an aggregate as a measure of health care improvement. In addition to sharing information about the individual participant’s improvement in health status with the participant, there needs to be accountability the larger community whose members provided the data, that the data will be used to improve their health. A plan should be put in place to share with the surrounding community from which the clinic’s participants are drawn, to plan how will the data be shared with the participants and community, and how will it be used to improve health of the participant and community members. CCCH believes that these items should be spelled out by an applicant to be a health care home.	Center for Cross-cultural Health, Sandra Eliason	No change. It is up to the clinic to as stated in 256B.0751 Subd. 2(a)(3)
171	1	C		Suggest adding preferred language and method of communication to learn about health. What about collecting education or spiritual information? Both impact one’s understanding and approach to health care.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	This request is beyond our scope of legislation.
172	1	C		What does it mean: “ Collect information about participants’ cultural background, racial heritage, and primary language and describe how the applicant will use this information to improve care???”	Bob Koshnick, MD (individual)	This will be addressed in training. The legislature has identified culture as a important consideration in providing care.

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173	1	C		This data collection is an invasion of privacy that the proposed health care homes don't need to collect and generates unnecessary time and expense that will discourage people to participate.	Bob Koshnick, MD (individual)	This will be addressed in training. A patient may decline to provide this information.
174	1	C		The only one I think holds water is the primary language. In a rural setting like ours, we don't have interpreters and pay several dollars a minute to access that through phone contacts, so we'd rather try to work things out with friends and relatives who can use the English language. That said it could be something that could be asked.	Bob Koshnick, MD (individual)	This will be addressed in training. See 256B.0751 Subd. 2 (a)(3) ...and providing care that is appropriate to the patient's race, ethnicity, and language.
175	1	C		The genetic correlates of skin color (commonly used to identify race) are hopelessly inaccurate and don't relate too much other than sometimes being a marker for socioeconomic class. The even more ambiguous concept of "cultural background" again relates more to economic differences rather the culture of origin. Using markers of economic disparities as factual required health care home monitoring criteria also goes against the philosophical grain of a colorblind society. Race and culture are largely subjective in the minds of the individual, who often has to weigh the economic pros and cons of self-identification.	Bob Koshnick, MD (individual)	This will be addressed in training. The legislature has identified culture as a important consideration.
176	1	C		The rule requires a clinic to collect this information. There is no reference made to the patient's right to choose to not disclose the information; the patient's rights appear to be superseded by the requirement.	Northstar Physicians Network, Bruce Penner, RN	A patient can always refuse. This does not abrogate the other laws in place.
177	1	D	Lines 11.23 - 11.25	Multiple interpreter agencies, qualified interpreters and telephone interpreting services are available. CCCH believes that there is no lack of technical capability to provide interpreting services, and it is a violation of the civil rights act to not provide qualified interpreters. CCCH believes that the words "if that means of communication is available within the health care home's technological capability" should be stricken. Addition, since many patients are part of oral communities, which do not have the ability to read or write their own language, provisions need to be used to get information to patients which is not necessarily written information.	Center for Cross-cultural Health, Sandra Eliason	No change. It is up to the clinic to as stated in 256B.0751, Subd. 2 (a)(3)
178	1	D		Where is the language requiring alternative means of communication such as TTY?	Seven County Senior Federation, Lisa A. Krahn	See 0040 Subpart 1D document that the applicant is using participants' preferred means of communication,, if that means of communication is available within the health care home's technological capability;
179	1	E		Lines 12.3 to 12.4 make the participant responsible for determining whether specialty care resources are covered by his or her insurance. It would be a better approach to make this the responsibility of the care coordinator. Many people who would most benefit from a care	Minnesota Disability Law Center, Jennifer E. Giesen	The patient retains his or her rights to choose a provider even if that specialist is not part of the primary care providers practice group but this right carries the responsibility of determining his

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				coordinator/health care home team are not able to take this step themselves because of their complex/disabling condition. To make them responsible for dealing with the insurance company is going to undercut the successful implementation of the health care home and will defeat the purpose.		or hers insurance will cover their care. The provider under shared decision-making is responsible for sharing specialty information to assist the patient in decision making.
180	1	E		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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Privacy laws are unchanged with this rule.
181	1	E		Referrals: Part 4764.0020, subpart 32, defines a referral as a recommendation from the certified health care home "that the participant receive an evaluation, treatment, or services from a provider outside of the health care home." And part 4764.0040, subpart 1, paragraph E, specifically requires a certified health care home to inform participants that he or she may choose to receive care outside of the health care home, but that "the participant is then responsible for determining whether specialty care resources are covered by the participant's insurance." It remains unclear what the purpose of referrals is in a fee for service benefit model with open access to providers. Blue Cross believes this raises a number of questions, including but not limited to: 1) Are health plans to align referrals with claims payment? 2) The proposed rules do not require the health care home to inform the health plan of any referral, so how is the health plan to know a referral was given? 3) Does this mean that claims for care outside of the health care home should not be paid unless paired with a written referral? If so, how is that reconciled with current statutory requirements on health plans in the treatment of referrals? 4) What is the relationship between a referral and a prior authorization? 5) What if a referral is given for a service that does not meet medical necessity criteria? 6) It is the member's benefit set that supports what a health plan pays for. What happens if a referral is given for services not covered under the	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	See 0020 Subp. 32 Definition of Referral. In addition, the patient retains his or her rights to choose a provider even if that specialist is not part of the primary care providers practice group but this right carries the responsibility of determining his or hers insurance will cover their care. The provider under shared decision-making is responsible for sharing specialty information to assist the patient in decision making.

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				participant's health care insurance coverage? 8) How will a referral impact appeals? If there is a return to a referral system, this will be a large administrative burden for health plans, providers, and patients; will increase administrative costs across the entire health care system; and will be very resource intensive and expensive.		
182	1	E		When referring a health care home patient to a specialist, the wording in the proposed rule would require our providers to inform patients of specialist outside our health system that they may choose. We would like the wording to be changed to reflect that we will honor a patient's request to seek specialty care outside our health system. But we do not want to be required to tell them of other specialists. We feel it is in the best interest of the patient to keep their care, whenever possible in our system, because of the continuity of care, quality of care and enhanced communication with our electronic medical record system.	St. Mary's Duluth Clinic Health System, Thomas G. Patnoe, MD, President/ Chief Medical Officer	No change. The patient retains his or her rights to choose a provider even if that specialist is not part of the primary care providers practice group but this right carries the responsibility of determining his or hers insurance will cover their care. The provider under shared decision-making is responsible for sharing specialty information to assist the patient in decision making.
183	1	F		Where are the privacy protections for the patient, as each call to the "on-call provider" would be noted as conversations to be converted into permanent data and added to the digital database?	Seven County Senior Federation, Lisa A. Krahn	Privacy laws are unchanged with this rule. This will be addressed in training.
184	2			We fully endorse the following components of the rule: The stipulation that health care home recertification requires demonstration that patients take an active role in managing their health care.	Minnesota Breast Cancer Coalition, Christine K. Norton	No change recommended.
185	2			I was encouraged to see many references to cultural, spiritual, and literacy needs of patients. With the National Assessment of Adult Literacy reporting over 1/3 of Adult English Speaking Americans at basic or below basic health literacy and ever increasing disparities in health care, it is important as we move forward to consider the context our patients come from and return to after seeking care.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	No change recommended.
186	2			Suggest the following change: "...and that the applicant has improved participant understanding and involvement by addressing one of the following." Thank you for adding literacy level into this section.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	Rule word change. We deleted "improved" and inserted "demonstrated".
187	2			How do you demonstrate that the applicant has improved participant involvement and communication by addressing on of the following: participant's readiness for change (what if they're healthy), literacy level (we're now responsible for their literacy education?), or other impediments to learning? The entire subparagraph. 2 should be eliminated as impractical and unrealistic. Home health care homes should not be in the business of mind reading and primary level education.	Bob Koshnick, MD (individual)	Rule word change. We deleted "impediments" and inserted "barriers". The Joint Commission requires an assessment of the patient's ability to understand "health" literacy.
188	2			Line 12.16 refers to "participant's readiness for change, literacy level, or other impediments to learning." Does this	Minnesota Disability Law Center, Jennifer E.	Rule word change. We deleted "impediments" and inserted "barriers". The Joint Commission

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				refer to their literacy level regarding their condition? Impediments to learning about their condition? Clarification is needed. Subpart 5, lines 14.8-14.9 require the care coordinator to coordinate referrals for specialty care, another reason why it makes sense for the care coordinator to be responsible for dealing with the insurance company.	Giesen	requires an assessment of the patient's ability to understand "health" literacy which is the patient's ability to read, understand and act on health care information. This does refer to their literacy level regarding their condition.
189	2			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 health or wellness 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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Rule word change. We deleted "addressing" and inserted "identifying and responding to".
190	2			How would an applicant demonstrate "improved participant involvement and communication by addressing one of the following: participants' readiness for change, literacy level or other impediments to learning? This requirement for recertification should be eliminated or practical and validated tools should be provided.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	This will be addressed in training. MDH will have a tools section on the health care home webpage for providers and patients.
191	2			Demonstration of this standard should be kept administratively feasible, i.e. by documenting policy or procedure, reporting on training provided, or indicating where this information would be documented. Additional administrative overhead would be incurred if satisfaction of this standard required a chart audit to show how the information had been recorded.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	This will be addressed in training.
192	2			Providers should not be expected to address a patient's readiness for change, literacy level or other impediments to learning other than those related to health and wellness.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	This will be addressed in training. All health care home activities are related to health and wellness.
193	2			Unchanged -- problem not addressed - It may be difficult to demonstrate improved participant involvement and communication if the participants were engaged to begin with (families with complex pediatric needs often are very engaged to begin with -- will be tough to show	Courage Center, Jan Malcolm/John Tschida	Rule word change. We deleted "addressing" and inserted "identifying and responding to".

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				improvement). Literacy one of the recertification issues to address		
194	2	E	Lines 12.11 -16	Through experience and relevant research, CCCH is aware that culture affects participation, and no one approach will fit all cultural communities. How participants are encouraged to take an active role in their health will look different depending on the location of the clinic and the culture of the patient population. It is not only "participants' readiness for change, literacy level, or other impediments to learning" that need to be addressed, but also cultural barriers, root causes, Socioeconomic status, family and community involvement, etc. Larger processes than just that between the patient and provider need to be addressed.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	This is not the focus of this particular provision. It is addressed elsewhere in the rule.
195	3	A		Although the term is mentioned several times in the proposed rules, "gaps in care" is not defined in 4674.0020.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	This will be addressed in training.
196	3	A		See comments above (under 1.12) regarding registry	Center for Cross-cultural Health, Sandra Eliason	Cultural will be addressed in training.
197	3	A,B		HIPAA rules provide for medical data to be stripped of certain markers and resold to private firms. Where are the protections for Minnesotans' medical data to be kept out of the private market in these definitions? Is not this statute just creating a new demand for such data to be traded and sold by private entities for shareholder enrichment?	Seven County Senior Federation, Lisa A. Krahn	See 0040 Subp. 1 F. Privacy laws are unchanged with this rule. This will be addressed in training.
198	3	B	2	The registry is useful for chronic conditions and preventive care. but (2) we're supposed to report on any gaps in care for specific subgroups of participants with a chronic or complex condition? Again, how are we going to be doing this sub grouping? Who do we report those subjective summaries to? What is the content they're looking for and why? That's different than following outcomes as part of quality of care monitoring. I really don't think this has any place in the proposed rules.	Bob Koshnick, MD (individual)	This will be addressed in training. It is up to the individual clinic to address this in their own policy and procedures. It is for internal use and not for public reporting.
199	3	B	2	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, 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.	Minnesota Hospital Association, Matthew L. Anderson, JD	This will be addressed in training. It is up to the individual clinic to address this in their own policy and procedures. It is for internal use and not for public reporting.
200	3	B		Hennepin County Medical Center's recent development of a	Minnesota Association of	This will be addressed in training. The rule is

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				web-based asthma registry outside of their established EHR demonstrates the importance of focusing on functionality rather than location of data. The information included in this section is appropriate, but it is unnecessarily prescriptive to specify where the data will reside (registry vs. EHR vs. paper record). Experience with stand-alone registries has also shown that trying to maintain contact information in multiple systems is prone to error. Let each clinic determine where information will be stored and focus on the functionality their combined systems must have, as was done in 0040.4.	Community Health Centers, Rhonda Degelau, Executive Director	requiring providers to show they have a systematic way of evaluating their patient population. The key is to identify patients whose follow up care might fall through the cracks.
201	3			Part 4764.0020, subpart 25, defines a participant as "a patient... who has elected to receive care through a health care home." This election to participate by the patient would presumably be recorded by the health care home as required in part 4764.0400, subpart 3, which does require the certified health care home to use an electronic patient registry "to record participant information and track participant care." However, it is not entirely clear how the participant's health plan or insurance coverage is notified of this election. It is very important to ensure that an individual affirmatively chooses to enroll in the health care home and understands the responsibilities that coincide with this participation. These rules are silent on how a participant would disenroll from their chosen health care home. Additionally, the rules are also silent on how long a participant must remain enrolled with one health care home before being allowed to elect a different home. There needs to be a procedure in place for disenrollment or changing to a different home in order to prevent an individual from being enrolled in more than one health care home at a time. Furthermore it must be stated clearly in the rules that simultaneous participation in multiple health care homes is prohibited. Paying a care coordination payment to more than one health care home for the same participant will not result in any savings but instead raise costs.	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	The design process of how an insurance company will be notified is being determined by the Payment Methodology Workgroup.
202	4			These issues are better handled in the care plans, not as a separate report.	Bob Koshnick, MD (individual)	The "gaps in care" are identified through the systematic review and the corrective measure is made in the care plans.
203	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	Minnesota Hospital Association, Matthew L. Anderson, JD	This will be addressed in training. Identifying gaps in care is a preventive measure. It does not necessarily connote provider errors or omissions.

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				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.		
204	4			Will Health Care Homes who have implemented appointment reminders for the first year recertification qualify for a higher care coordination fee?	SuperiorHealth Lakewalk, Carol Farchmin, MD	No.
205	4	E	6	The rule should add the patient as decision-maker with care team in the determination of external care plans relevant to HCH. Rule should state that HCH will collect only those external plans that the patient has disclosed or provided prior consent or authorization.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	The patient disclosure or authorization is assumed. The participant is part of the care team.
206	5	A	1	Navigation and the ability to find resources is very difficult for those with low health literacy, so this is a great addition as well.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	No change recommended.
207	5	A	1	"set goals" - Useless definition - will not provide clarity to any system considering developing a medical home or for the state in evaluating their success..	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Setting goals is a common element of care planning.
208	5	A	2	How will "continuity of care" be reported and measured? Will different levels of continuity carry different levels of reimbursement?	SuperiorHealth Lakewalk, Carol Farchmin, MD	This will be addressed in training, and as an administrative procedure during verification. Different levels of care will carry different levels of reimbursement. In 256.0753 Subd. 1. ...The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination.
209	5	A	2	Useless definition - will not provide clarity to any system considering developing a medical home or for the state in evaluating their success.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Noted
210	5	A	3	This is a very important requirement as patients often have a variety of different providers involved in their care as well as community resources they rely upon for physical and emotional needs.	American Cancer Society - Minnesota, David F. Arons, Director of Government Relations	No change recommended.
211	5	A	3	This seems appropriate, but it potentially conflicts with the CMS requirement of face-to-face visits every 6 months to trigger billing/reimbursement.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	The two are not incompatible. The CMS requirement is independent of the rule. The Health Care Home rule covers the new care coordination payment.

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212	5	A	3	Suggest that rule clarify that the participant may contact the provider- the current wording directs all communication from the provider to the participant, which appears to be counter-productive to patient-centered care.	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President and Katherine Cairns, Executive Director	Rule wording change. 0040 Subp. 5 A (3) the health care home team and participant determine whether and how often the participant will have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care.
213	5	A	3	Suggest that rule clarify that the participant may contact the provider- the current wording directs all communication from the provider to the participant, which appears to be counter-productive to patient-centered care.	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	Rule wording change. 0040 Subp. 5 A (3) the health care home team and participant determine whether and how often the participant will have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care.
214	5	B	3	The payment methodology expects to include risk adjustment and the Quality Incentive Payment System expects to include risk adjustment, because clinics that see a disproportionate share of disadvantaged patients are not likely to show the same levels of performance or improvement as clinics that serve primarily a mainstream population. Recommendation is to include some form of risk adjustment in the benchmark process. See next response, below.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	This is part of the charge for the Outcomes Measurement Advisory Committee.
215	5	B		Again – defining the members of the team specifically, and the outcomes desired only relatively is not congruent with the work required to move from the current state of the medical home concept to an optimized endpoint.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	The comment is not clear.
216	5	B,C, D		Good points in helping the care coordinator to keep pertinent and involved	Lakewood Health System, John Halfen, MD	Noted. Thank you.
217	5	C		See comments for 0020 Subp 5. Consideration should be given to allowing a sharing of resources (care coordination functions) between clinic sites or even between clinics in a network and not having exclusive care coordinators or clinic exclusive care coordination at each site. There are solo practices that will be unable to provide all of the care coordinating functions, let alone a designated care coordinator. The MSHO care coordination model proves that similar functions can be performed in this manner.	Northstar Physicians Network, Bruce Penner, RN	No change. There are no mandates for additional labor force, only requirements for new functions. Those functions may be done within the current labor force.
218	5	C		The requirement that a care coordinator be located at the same site as the personal clinician may be overly burdensome for small practices that cannot afford to staff an on-site care coordinator due to the small number of patients they serve. We fully support the inclusion of a care coordinator & believe a care coordinator is an integral part of the care team. We don't want the care coordinator to be	Minnesota Breast Cancer Coalition, Christine K. Norton	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician" and defined direct communication requirements.

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				seen as a distant resource but because of small patient volumes in some areas, we encourage the addition of a provision in the rule that would provide exceptions for practices that can demonstrate the need for a shared care coordinator.		
219	5	C		"locates the care coordinator..." This is an important element, it's what is going to make HCH work (having a dedicated person for care coordination that will get paid for it) and it's an integral part of HCH; it's good to see this in here.	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician" and defined direct communication requirements.
220	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician" and defined direct communication requirements.
221	5	C		The rules require that the health care home must provide the care coordinator with dedicated space and time to perform care coordination functions, located at the same site as the provider. Small rural clinic systems may not be able to assure that a care coordinator is always at the same site as the personal clinician. A specific variance should be defined for clinics that are too small to be able to meet this standard. A standard variance would save precious time for those clinics, rather than requiring each of them to complete a complicated variance application process.	Minnesota Medical Association, Robert Meiches, MD	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician." Rule change. 0040 Subp. 5 D. We deleted "space."
222	5	C		Care Coordinators within one system should be able to support other sites when the staff person is on PTO (paid time off: vacation, sick, etc)	Park Nicollet Health Services, Amy Burt, DO	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician."

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223	5	C		Small rural clinic systems may not be able to assure that a care coordinator is always at the same site as the personal clinician. A specific variance should be defined for clinics that are too small to be able to meet this standard. A standard variance would save precious time for those clinics, rather than requiring each of them to complete a complicated variance application process.	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician."
224	5	C		Care Coordination Requiring that the care coordination and the provider be at the same location is too restrictive. Part 4764.0040, subpart 5, paragraph C, requires the certified health care home to locate "the care coordinator at the same site as the personal clinician or local trade area clinician" (emphasis added). While on-site care coordination may be an ideal model, this is entirely too restrictive. This would prohibit many smaller clinics that do not have the economic resources to employ an on-site care coordinator but yet meet all of the other requirements for certification as a health care home. Furthermore, this limitation of requiring only on-site care coordination would likely disproportionately affect smaller clinics in Greater Minnesota, where access is often a challenge. This would prevent these smaller clinics from being allowed to partner with a health plan to assist in care coordination. Health plans can provide a wide range of expertise and roles in supporting health care homes, for clinics and clinic systems, depending on the infrastructure and capacity of the health care home, such as: 1) help to identify patients who have opportunity for care coordination and case and/or disease management services; 2) clinical staff to perform outreach services to patients to provide care coordination and case and/or disease management services; 3) computer platform/software for clinicians to document services provided by the clinician; 4) reporting from claims data and/or computer platform/software that demonstrates the value of services provided; 5) assistance with report interpretation to be used to improve on services provided to patients; 6) consultation to clinics in any of the areas above. Additionally, there should be inclusion of other models that have been shown to be successful, including a county-supported system of care coordination. The rules should also take into consideration all of the different means with which to communicate through technology today that do not necessitate only on-site care coordination, including but not limited to: email, instant messaging/chat, phone, etc.	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician."
225	5	C		It is not clear whether this implies the care coordinator must be on-site at all times, or whether the coordinator may be working between two sites with dedicated time with the providers at each site. The latter may be likely in both urban and rural areas.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician."

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226	5	C		What allowances are made for providers and patients who give and receive their care at different physical sites, even though there is access to the same electronic record?	SuperiorHealth Lakewalk, Carol Farchmin, MD	Rule wording change. We deleted "locates the care coordinator at the same site" and emphasized the direct communication component.
227	5	C		It our understanding this part of the rule means a care coordinator needs to be located at each HCH site. In provider groups with multiple locations, there may be care managers that can cover more than one site depending on the number of participants in the program. Additionally, it may be more effective for large provider groups to centrally locate the care managers where care management staff may collaborate more easily. Therefore providers should be allowed to determine appropriate geographical location of care management staff.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	Rule wording change. We deleted "locates the care coordinator at the same site" and emphasized the direct communication component.
228	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" "The rule should be changed to allow providers to innovate" Comments from John Anderson – MHA – we concur.	HealthEast Care System – HMRI Clinics, John Piatkowski, MD, MBA	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician."
229	5	C		Unchanged. -- problem not addressed - Why do the coordinator and clinician have to occupy the same physical space in place & time where virtual communication is increasing and becoming the standard. Close proximity does not ensure better communication.	Courage Center, Jan Malcolm/John Tschida	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician" and emphasized the direct communication component.
230	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Rule wording change. 0040 Subp. 5 C. We deleted "locates the care coordinator at the same site as the personal clinician or local trade area clinician" and emphasized the direct communication component. Rule change. 0040 Subp. 5 D. We deleted "space."
231	5	D		Under the standards – Care coordination : 14.4 D: "...dedicated space and time...". With limited resources,	NorthPoint Health and Wellness Center, Paul	There are no mandates for additional labor force, only requirements for new functions.

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				care coordination will need to be performed by our entire team – it may be the MD, the RN, the MA, a care coordinator (but we may not have a specific position for that function) our social worker, medical office assistant, etc. the idea that we will hire a Care Coordinator, give them an office and have them do the work is unlikely in these economic times, so our “care coordinator” could be many people working to coordinate the care, so I would recommend not limiting us to a “dedicated space and time”.	Erickson, MD	Those functions may be done within the current labor force.
232	5	D		Will the MDH provide some expectation about how the allotted time is determined or will this be up to each Health Care Home to determine?	SuperiorHealth Lakewalk, Carol Farchmin, MD	This is up to each Health Care Home to determine.
233	5	D		Dedicated time for care management implies that a care manager will be available only during a specified time period. The rule should remain flexible with respect to scheduling and allow HCH to manage care coordinator time as appropriate.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	The dedicated time for care coordination is up to each Health Care Home to determine.
234	5	D		Unchanged -- problem not addressed - Why dedicated space? Care coordination could take place in a space that is also used to analyze QI or even in an exam room with a desk & computer when otherwise not in use. Square footage is a premium commodity in a clinic	Courage Center, Jan Malcolm/John Tschida	Rule change. 0040 Subp. 5 D. We deleted "space".
235	5	E		Excellent description of vital tasks. Includes both care and utilization management components to maximize effectual and economical use of resources.	Northstar Physicians Network, Bruce Penner, RN	No change.
236	5	E	4	Will the MDH mandate that discharging physicians have phone contact with the Health Care Home at time of discharge to facilitate post discharge planning?	SuperiorHealth Lakewalk, Carol Farchmin, MD	There is no requirement, however, Health Care Homes are encouraged to develop systematic planning with in-patient physicians to optimize discharge planning.
237	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	See 0020 Subp. 22. Definition of Health Care Home team or care team.
238	6			Excellent criteria	Lakewood Health System, John Halfen, MD	No change recommended.
239	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	Minnesota Hospital Association, Matthew L. Anderson, JD	The department has neither legislative authority nor the intention to apply the benchmarks retrospectively.

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				based on benchmarks that were unknown or undesignated at the time services were delivered.		
240	6	A	Lines 14.21 - 14.25	See comment above regarding care coordination (Subp 3, line 2.1) How patients engage in care will look different for each racial/ethnic community, and will often include more than just the patient, including but not limited to family members, often extended family, community organizations, faith communities, and others. It will be important that community elements, relating to cultural values, are made a part of the care plan when relevant. How this is tracked, how accountability is measured, and how successes are documented for implementation in other, similar communities, will be important. Additionally, how participants evaluate their opportunity to fully engage in care planning and shared decision making need to be evaluated. CCCH proposes an evaluation system that directly measures patient assessment of their involvement.	Center for Cross-cultural Health, Sandra Eliason	This will be addressed in training. The legislature has identified culture as a important consideration.
241	6	A		Lines 14.24 –14.25: It is shared care-planning, not shared decision-making. The participant has more of a role than “feedback.” Unless the participant is legally incompetent to make medical decisions, it is the participant’s responsibility to ultimately make the medical decisions regarding the care he or she receives.	Minnesota Disability Law Center, Jennifer E. Giesen	No change. These concerns are already addressed in the rules. The rules don't change the participant's right to make autonomous decisions. Instead they compel the care team to share information and collaborate.
242	6	A		How will this be demonstrated? In terms of administrative burden, avoid chart review requirements whenever possible.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	This is an administrative procedure.
243	6	B	Lines 15.3-15.6	CCCH recommends that community-based organizations be added to this list.	Center for Cross-cultural Health, Sandra Eliason	Rule word change. We added community"-based organizations".
244	6	B		Another community or government resource that should be coordinated with includes those services that aid injured workers, and cancer survivor groups	American Cancer Society - Minnesota, David F. Arons, Director of Government Relations	No change. Community-based organizations covered this.
245	6	B		Community Health Workers and Community Paramedics should be specifically added to the list of other professionals after the words “such as”.	North Central EMS Institute, Gary Wingrove	No change. Community-based organizations covered this.
246	6	B		Unchanged -- problem not addressed - What constitutes “working with” a community or public health resource? Who decides that these non-medical resources have been “worked with”?	Courage Center, Jan Malcolm/John Tschida,	This will be addressed in training. This intentionally allows for a broad variety of methods to work with the community.
247	6	D		The Down Syndrome Association of Minnesota is excited about the concept of health care homes. I especially noted the reference to Transition planning (15.9), which is an area	The Down Syndrome Association of Minnesota, Kathryn L. Nelson	We agree.

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				of particular concern to families in Down Syndrome world. Families report difficulty in locating specialists with experience and interest in working with people with Down syndrome. Also, the transition from pediatric to adult medicine is often problematic.		
248	7	A	1	See comment under 2.2-2.5 above regarding patient engagement in care coordination.	Center for Cross-cultural Health, Sandra Eliason	This has been already addressed.
249	7	A	1	What do you mean by "actively engage the patient". Perhaps this could be added to the definitions section.	Minnesota Health Literacy Partnership, Alisha Ellwood, MA, LMFT	This will be addressed in training.
250	7	A	2	Good improvement from previous version	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	No change recommended.
251	7	A	2	Suggest adding "dietitian" to the list of potential members of the care team since many patients have chronic health conditions and could benefit from therapeutic diet counseling/education in their care plan to deal with obesity, heart disease, high blood pressure, diabetes, etc	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	Rule change. We added "dietitians".
252	7	A	4	It will be important to measure toward whose goals the progress is measured. If the patient does not understand, or is not prepared to accept, for example, that Hgb A1C is the appropriate measure of diabetes control, and is instead focused on other conditions, such as that which causes pain, progress from the patient's perspective will not be reached. Goals should be written in language the patient understands and with the patient's consent that those are the goals important to the patient, or alternatively, patient goals should be incorporated into the plan.	Center for Cross-cultural Health, Sandra Eliason	This will be addressed in training.
253	7	A	5	Great, very positive	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	No change recommended.
254	7	A	5	This must be written in language that the patient understands and is in agreement with.	Center for Cross-cultural Health, Sandra Eliason	This will be addressed in training.
255	7	A	6	The rules state a care plan must document the use of evidence-based guidelines for significant medical services and procedures, if such guidelines and methods are available. The MMA notes that "significant medical services and procedures" are not defined in the rules and we would	Minnesota Medical Association, Robert Meiches, MD	Rule word change. We deleted "significant".

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				suggest clarification by the departments as to what procedures are envisioned and what documentation is expected. In addition, this provision is somewhat troubling in that it seems to imply that evidence-based care is not otherwise required unless specified by the law.		
256	7	A		Current wording makes it sound like a care plan is not mandated; this statement should be stronger, care plan is the back bone to HCH. Change to: "establish and implement policies and procedures to guide the health care home in implement care plans for participants with complex or chronic conditions".	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	This will be addressed in training. Based on the clinic's culture, the clinic determines which of its patients requires a care plan but ultimately the participant and clinician make this decision together. We have defined care plan in a broader perspective.
257	7	A		This provision implies that a provider does not necessarily have to have a health care plan for the patient and, instead, need only have policies and procedures to assess whether a health care plan will benefit a particular patient. A health care plan is essential to effective health care home services. Therefore, this section should remove the words "assessing whether" and replace them as follows: "establish and implement policies and procedures to guide the health care home in implementing a care plan that will benefit participants"	Minnesota Disability Law Center, Jennifer E. Giesen	This will be addressed in training. Based on the clinic's culture, the clinic determines which of its patients requires a care plan but ultimately the participant and clinician make this decision together. We have defined care plan in a broader perspective.
258	7	A		The rule states that the health care home must establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. While the MMA acknowledges that this issue may be clarified through the development of the payment methodology, this standard remains ambiguous on its own. Again, we would urge the departments to clarify whether the individual health care homes will be able to determine the conditions/complexity of patients for whom care plans will be developed or whether there will be some minimum expectations/standard definitions across all health care homes.	Minnesota Medical Association, Robert Meiches, MD	This will be addressed in training. Based on the clinic's culture, the clinic determines which of its patients requires a care plan but ultimately the participant and clinician make this decision together. We have defined care plan in a broader perspective.
259	7	A		We would encourage that each health care system develop a policy regarding who will have care plans recognizing that patients may choose not to be involved or resources are not adequate to provide care plans for all participants.	Park Nicollet Health Services, Amy Burt, DO	The standard supports this comment.
260	7	A		Additionally, part 4764.0040, subpart 7, paragraph A, requires only that a certified health care home "establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions" (emphasis added). Blue Cross believes that all patients with a complex or chronic condition would benefit from a care plan and, as such, a health care home should be required to develop a care plan for all participants. The reimbursement for the creation of a care plan needs to be included within	Blue Cross and Blue Shield of Minnesota, Phil Stalboerger, Vice President, Policy and Legislative Affairs	The payment methodology workgroup is addressing the care coordination payment.

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				the care coordination payment.		
261	7	A		Recommend adding section between 4 & 5 "verify and ensure joint understanding of the care plan by having patient demonstrate understanding of care plan"		Rule change. We added ..."and verify and ensure joint understanding of the care plan;"
262	7	A		Allows autonomous decision making on the part of the HCH. Are there criteria for how these policies and procedures will look that are not published in these rules or is the HCH allowed to develop these independently?	Northstar Physicians Network, Bruce Penner, RN	HCH are allowed to develop the policies and procedures independently.
263	7	B	1	Unchanged -- B.3 can be read to possibly include secondary prevention ?? - Need to make it clear that preventive care needs to include secondary prevention regardless of underlying complex condition. (E.g. a patient who is disabled does not also need to develop diabetes or depression...)	Courage Center, Jan Malcolm/John Tschida	No change. Preventive care includes secondary care. Prevention is broadly implemented.
264	7	B	4	Line 16.10 refers to "advance" directives, but in Minnesota the statutory term is "health care directive," which includes end of life directives and, by incorporation, advance psychiatric directives.	Minnesota Disability Law Center, Jennifer E. Giesen	Rule change. We deleted "advanced" and inserted "health care."
265	7	B	1,2,3,4	All of these must be culturally appropriate, and documentation of understanding from the patient that these elements in the care plan and understood by and expected by the patient should be obtained.	Center for Cross-cultural Health, Sandra Eliason	Rule change to 4764.0040 Subp. 7 A (1) to address this concern for Subp. 7 B (1-4). We added ..."and verify and ensure joint understanding of the care plan;"
266	7	B		Will there be mechanism for adjusting the care coordination payment when a Pt receiving preventative care is found to have a chronic condition?	SuperiorHealth Lakewalk, Carol Farchmin, MD	This is being addressed by the payment methodology workgroup.
267	7	B		What mechanisms will be in place if a participant's goals and action plan conflict with the provider's or with established disease management goals?	SuperiorHealth Lakewalk, Carol Farchmin, MD	This is up to the HCH to collaborate with the participant in determining goals and actions.
268	7	B		Suggest that the care plan also include contact information for the clinic/personal clinician and care coordinator so that when the care plan is used at an emergency department, hospital, or out of the usual service area, there is contact information for improved communication/coordination.	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President and Katherine Cairns, Executive Director	Each HCH is responsible for developing its own care plan. Sample care plans will be posted on the HCH website.
269	7	B		Suggest that the care plan also include contact information for the clinic/personal clinician and care coordinator so that when the care plan is used at an emergency department, hospital, or out of the usual service area, there is contact information for improved communication/coordination.	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	Each HCH is responsible for developing its own care plan. Sample care plans will be posted on the HCH website.
270	7	C		There will need to be a defined process for how Pt's care will be transferred to a different provider if/when the provider's certification is terminated.	SuperiorHealth Lakewalk, Carol Farchmin, MD	This will be addressed in training. Each HCH will be responsible for the communication to the participant if the provider's certification is terminated and how the transfer to a certified

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						provider will occur.
271	7	C		Again, the HCH autonomy is appreciated but to what level does the HCH actually define these criteria?	Northstar Physicians Network, Bruce Penner, RN	The health care home defines the criteria. The overall health care home results will be demonstrated through 0040 Subp. 10.
272	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.	Minnesota Hospital Association, Matthew L. Anderson, JD	This will be addressed in training. See 256B.0751 Subd. 2(a)(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions.... A patient can always refuse to provide the authorization of release to the health care home.
273	9	A	3	They should be required to have 2 participants in their collaborative and collaboratives generally should have parent/patient participation; language is a little soft. Use the same language as in A (17.2) in 17.16.	Minnesota Department of Health, Health Care Homes Consumer and Family Council, Rebecca Schlough	Rule change. We added "two or more participant representatives who were provided the opportunity and encouraged to participate"... We cannot legislate families and participants to participate.
274	9	A	3-Jan	This venue, with one or two patients participating with a group of experts, has been shown to intimidate the patients and prevent them from actively speaking up. A better means of receiving feedback in the community is via their community organizations or listening or focus sessions. To succeed and impact outcomes and quality in a significant manner, the health care home must receive accurate feedback from community participants.	Center for Cross-cultural Health, Sandra Eliason	We cannot legislate families and participants to participate.
275	9	A		Please clarify for the larger clinic systems the requirements for Quality Improvement teams. Do we need: one team per department, one team per clinic, or one team per organization? What is reasonable and cost and time effective?	Park Nicollet Health Services, Amy Burt, DO	This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
276	9	A & C		In the language on learning collaborative, the rules list the specific participants from each Health Care Home. For care systems or clinic groups that use a unified health care home structure across clinics, we believe that it would be unnecessary for a provider, care coordinator and business operations person from each site to be in a learning collaborative. We recommend that there be a provider, care coordinator and business operations person representing the entire care system or clinic group. Otherwise this becomes an onerous and resource intensive effort for a care system. A similar concern arises on quality improvement teams. If a care system or clinic group uses a standardized approach and is led by a steering committee, it seems	HealthPartners, Inc., including HealthPartners Medical Group and Clinics, Beth Averbach, MD, and Pat Courneya, MD	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.

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				overzealous (and extremely duplicative) to require that at least five people at each clinic be part of a quality improvement team. We would certainly agree that quality improvement teams are important. However, for a care system or clinic group, we recommend more flexibility on site-specific quality improvement teams.		
277	9	B	2	The proposed statewide quality reporting measures are expected to incorporate a modified CAHPS tool for measuring patient experience. The methodology will require mail or telephone surveys. Historically mail and telephone have not been effective methods for reaching the often-mobile CHC patient population that is also sometimes wary of material or contact they aren't expecting. While the health centers can use the CAHPS tool itself, the methodology will be ineffective. Perhaps a variance can allow clinics that serve such populations to continue handing these surveys out at clinic visits and offering privacy for completing and handing in the surveys.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	The Community Outcomes Measurement Advisory Committee is addressing measurement. A clinic may submit a request for a variance.
278	9	B	3	More needs to be specified in terms of how this will be measured. Avoidance of ED and hospital visits will often be beyond a clinic's ability to measure, having no baseline or having a baseline buried in older medical records. Perhaps there are indicators, such as the Optimal Diabetes Care measure, that serve as stand-ins for care that has been demonstrated in scientific study to reduce complications over wide study groups, meeting the criteria of cost-effectiveness. A patient that completes the preventive and chronic care services outlined in a care plan may be presumed to have received cost-effective care.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	The Community Outcomes Measurement Advisory Committee is addressing measurement.
279	9	B	17.5-17.7	See above under A(4) 115.22. The patient must understand the performance measurement and agree that he/she will consider it the most important indicator of improvement for his/her health.	Center for Cross-cultural Health, Sandra Eliason	So noted.
280	9	B		Are there additional criteria for the term "tracked changes?" Is an annual audit adequate: To make the playing field even across HCHs, is there a minimum standard for the quality of the data collection and reporting process that must be met to assure the validity of the reports from each HCH?	Northstar Physicians Network, Bruce Penner, RN	"Tracked changes" will be addressed in the training. The Community Outcomes Advisory Committee will be addressing the minimum standard for the quality of data collection and reporting process.
281	9	C		In an IPA environment, it would be logical that some of these functions be performed at the IPA administrative level and not be forced to the individual clinic level unless their resources allow. This section speaks of a potential involvement whose costs will not be recoverable by the clinics or HCHs, thus being more readily met at the network level.	Northstar Physicians Network, Bruce Penner, RN	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and

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						time effectiveness for an organization.
282	9	C	1	Small groups will be disproportionately affected if the same number of staff must participate in collaboratives as larger groups with more providers. Will there be an effort made to "prorate" participation based on the number of participants in a Health Care Home?	SuperiorHealth Lakewalk, Carol Farchmin, MD	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
283	9	C	2	This section should use the same language as subpart 9(A)(3). Like the quality improvement team, the health care home should be required to have two or more patient representatives. If the health care home cannot find at least two patient representatives, what does that say about the health care home?	Minnesota Disability Law Center, Jennifer E. Giesen	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
284	9	C	2	We fully endorse the following components of the rule: The stipulation that health care home recertification requires demonstration that patients take an active role in managing their health care.	Minnesota Breast Cancer Coalition, Christine K. Norton	No change.
285	9	C	1-3	The entire section has 3 musts for something that those of us in rural areas have no knowledge or experience with: health care home learning collaboratives. When you live in a small town many miles from other providers, with whom are we supposed to set up this health care learning collaboratives? This simply isn't realistic in rural areas along with all the other requirements. They can "encourage" these, but it shouldn't be "musts." This should be either modified or eliminated.	Bob Koshnick, MD (individual)	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
286	9	C	1 (c)	Unchanged although the term "clinic" is now defined. Issue remains however. If the certified entity is the individual clinician, then won't all certified clinicians need to participate in this	Courage Center, Jan Malcolm/John Tschida	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
287	9	C	1a	Please clarify for the larger clinic systems the requirements for number of required participants for the learning collaborative. i.e. one team per department vs. one team per	Park Nicollet Health Services, Amy Burt, DO	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home

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				clinic, or one team per organization. Plus need further clarification for physicians: one from Family Medicine or all 10 clinicians from the Family Medicine Clinic? Can each health system determine their representation for the learning collaborative? Consider adding language that requires each health care system to develop a policy on how learning collaborative information will be disseminated throughout the organization.		learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
288	9	C	2 Line 17.16 - 17.18 -	See Comment under 17.4 above.	Center for Cross-cultural Health, Sandra Eliason	Rule change. We added "two or more participant representatives who were provided the opportunity and encouraged to participate"... We cannot legislate families and participants to participate.
289	9	C	2 & 3	Unchanged although the term "clinic" is now defined. Issue remains however. Health care homes per se are not certified. How can you add a requirement on this (uncertified/undefined) entity? Won't these need to be requirements of the clinician?	Courage Center, Jan Malcolm/John Tschida	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
290	9	C	3 17.19 - 17.21	Being accountable for results by sharing them with the community will be the key to keeping participants involved and building trust within the community. It must be demonstrated that the goal of the health care home is better health for the patient, not about fulfilling state requirements.	Center for Cross-cultural Health, Sandra Eliason	Overall Health Care Home results will be available to the public.
291	9	C		The learning collaborative creates special and enormously time consuming problems for the smaller or more remote practice.	Monticello Clinic, Glenn Nemec, MD	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
292	9	C		Will there be adequate opportunity for all possible applicants throughout the state to participate in a health care home learning collaborative in time to be certified by July 1, 2010? If not, the requirement should be temporarily waived. A specific variance should be defined for clinics that are too small to be able to meet the collaborative participation standard. In-person participation may not be possible or affordable for clinicians, staff and participants. A standard	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A

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				variance would save time for those clinics, rather than requiring each of them to complete a complicated variance application process.		variance may be submitted to ensure cost and time effectiveness for an organization.
293	9	C		CCCH strongly recommends that language be added stating that the quality improvement standard state "17.2 (3) two or more participant representatives" From the same racial, ethnic, or cultural communities as comprise the majority of the patients in the clinic.	Center for Cross-cultural Health, Sandra Eliason	It will be the health care home's responsibility to provide participants the opportunity to participate in a health care home learning collaborative. We cannot legislate participant participation.
294	9	C		Please clarify the requirements of participation in the health care home learning collaborative. The language reads that each health care home would need at least 2 or 3 representatives. Since a health care home could be at a physician level or clinic level, it would add unnecessary complexity to have 2-3 reps for each physician or clinic. We would prefer to have one set of representatives for our entire health system.	St. Mary's Duluth Clinic Health System, Thomas G. Patnoe, MD, President/ Chief Medical Officer	Rule change 4764.0040 Subp. 9 C is now 9 D. We added to participating in a health care home learning collaborative "through representatives that reflect the structure of the organization and includes the following persons at the clinic level:"This will be addressed in training. A variance may be submitted to ensure cost and time effectiveness for an organization.
295	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 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.	Minnesota Hospital Association, Matthew L. Anderson, JD	Having a quality improvement program in a clinic is a standard operating procedure. Some level of commitment is required to obtain certification.
296	9			What efforts will be made to have Health Care Home quality improvement efforts be accepted for ICSI participation/ Health Plan mandates and provider Specialty Board certification? [Sometimes it seems we spend more effort measuring and reporting the care than providing the care.]	SuperiorHealth Lakewalk, Carol Farchmin, MD	So noted.
297	9			Applicants who have not yet been certified should not be obligated to comply with performance reporting or quality improvement standards until they receive certification. Reimbursement should then be contingent on provider meeting the conditions.	Allina Hospitals & Clinics , Susan Klug, Medical Home Project Coordinator	Having a quality improvement program in a clinic is a standard operating procedure. Some level of commitment is required to obtain certification.
298	9			Unchanged -- lack of clarity persists - Does "participants' experience" refer to participants in the overall health care home ("clinic"?) or those participants of the certified	Courage Center, Jan Malcolm/John Tschida	Rule change. 0040 Subp. 9. We deleted "participants' " and inserted patients' ". The focus is on all patients of the clinic so as to

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				provider? In other words, how is the certified provider's performance evaluated? Based on the performance of the participants assigned to them individually or to the "clinic" (not certified & not defined)?		discourage any potential "cherry-picking" of the certain patients.
299	10	B	1	Unchanged - "Improvement" should be broadly defined to include lack of decline & prevention of secondary conditions. For many complex patients, they will not ever improve (diabetes not cured), but don't need to develop complications (lose eyesight or limbs).	Courage Center, Jan Malcolm/John Tschida	Certain patient populations may merit a variance from the improvement requirement.
300	10	B		Consider changing the standard to "document" or "demonstrate" rather than "show" for improved evaluation of off-site performance review.	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President and Katherine Cairns, Executive Director	The comment is not clear.
301	10	B		Consider changing the standard to "document" or "demonstrate" rather than "show" for improved evaluation of off-site performance review.	Minnesota Dietetic Association Public Policy Committee, Stephanie Heim, RD and Katherine Cairns, MPH, RD	The comment is not clear.
302	10	B	1-3 lines 18.7-18.9	Improvement in health for the participant must be seen in terms that are relevant to the participant. Again, if a Hgb A1C has no meaning to a patient, reporting that result will not have relevance. Quality Improvement results need to be shared with the community, as an obligation of the clinic in response to community members' participation, in a way that is understood by the community and is relevant to them. CCCH believes that this requirement should be inserted. We also believe that the quality improvement data should be disaggregated by race/ethnicity/language, and be available for review by participants and community members.	Center for Cross-cultural Health, Sandra Eliason	The Community Outcomes Measurement Advisory Committee is addressing the use of outcomes data.
303	11	A & B	Lines 18.10 - 18.88	See comment under 18.9 above	Center for Cross-cultural Health, Sandra Eliason	The Community Outcomes Measurement Advisory Committee is addressing the use of outcomes data.
304	11	B	1	This paragraph suggests that to qualify for recertification, the whole of the applicant's primary care services patient population is to be evaluated against benchmarks, not just members of the HCH within that population. You will recall that this is a voluntary membership by patients into the HCH, and they will have resources not available to the rest of the patient panel. It is, therefore, only members of the HCH that should be compared to the benchmarks. This paragraph as written, though, suggests otherwise.	Hennepin County Medical Center, Craig Garrett, MD	Rule change. We added a 4764.0040 Subp 10 C "submit health care homes data in the manner prescribed by the Commissioner that is needed by the Commissioner to fulfill the health care homes evaluation requirements of 256B.0752 subd 2." The Health Care Home Community Outcomes Measurement Advisory Committee is addressing this.

**Health Care Homes Chart of Public Comment
Comments with MDH Response
Formal Comment Period: July 6, 2009 – August 6, 2009**

Rule Part 0040: Standards						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response
305	11	B		If the clinic is one that sees a large number of newly arriving immigrants/refugees from one year to the next, there may be a disproportionate and continuing drag on health indicators that has less impact in a clinic with a more stable population. This could result in an unintended incentive to avoid adding new patients to the health care home mix who will "bring down" performance. This might be avoidable by allowing stratification of data by the number of years/months the patient has been a health care home participant. Presumably the amount of time a patient has participated will translate into improved health.	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	The Community Outcomes Measurement Advisory Committee is addressing the method of outcomes data measurement.
306				The standards for health care homes should include a grievance or complaint process and information about the complaint process should be given to patients and should be maintained for inspection by the Commissioner for consideration during the recertification process. A complaint process can provide the Commissioner with valuable information. While a health care home could look good on paper (e.g., they have policy that says they incorporate the patient's knowledge, values, beliefs, and cultural background), there must be a mechanism to collect information from patients as to their perspective of whether the health care home actually did consider their knowledge, values, beliefs, and cultural backgrounds.	Minnesota Disability Law Center, Jennifer E. Giesen	The existing grievance or complaint process that the clinics have is adequate. Health Care Home patient experience data will be measured. See 256B.0751 Subd 2 (8).

Rule Part 0050: Variance						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response
307	1	A, B		These criteria for variance seem adequate to allow for a modified model in remote communities where continuous access might not be possible slower progress on attaining quality benchmarks in clinics who serve a disproportionate share of disadvantaged populations	Minnesota Association of Community Health Centers, Rhonda Degelau, Executive Director	So noted.
308	1	B		A key question about the criteria for a variance should also be "failure to grant the variance would result in hardship or injustice to the applicant's patient population."	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	This could be a consideration for seeking a variance.
309	1			Applicants with the most limited resources are the ones that are most likely to qualify for a variance, but the least likely to be able to have the time and expertise to "submit a petition."	Minnesota Academy of Family Physicians, Patricia Fontaine, MD, MS, President	The substance of the petition must simply explain the applicant's rationale.
310	1			From an IPA perspective it is logical that a variance would be granted to member clinics/providers that could take advantage of the network's resources to accommodate	Northstar Physicians Network, Bruce Penner, RN	So noted.

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Rule Part 0050: Variance						
				some of the requirements for certification. In essence, this is no different than what will occur under a system-owned clinic model where the corporate resources are applied to a site's benefit. While not actually owning their member clinics, an IPA may be able to provide support and/or services to it's' members in a similar fashion.		
311	3	B, C		Adds some specificity - Overly broad & subjective. Could be difficult to manage over time. Once "varied" does the clinician get variance in perpetuity? What is the process to get back in the "normal" recertification process? What happens if several clinicians in a "clinic" are certified under the variance and several go through the regular process? To which standard is the health care home held?	Courage Center, Jan Malcolm/John Tschida	This will be addressed in training. It is an administrative process.

Rule Part 0060: Appeals						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response

Rule Part 0070: Revocation, Reinstatement, and Surrender						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response
312	3			A Health Care Home may determine that the per-person care coordination payments do not cover the expense of providing the care. If a Health Care Home surrenders their certification, how will the participants' care be transferred to another provider? Will the original Health Care Home continue to provide fee for service care or will all care be transferred?	SuperiorHealth Lakewalk, Carol Farchmin, MD	It is up to the patient where the patient is going to seek care.
313	3			Consider clarifying other reasons for surrendering the HCH certification or a transfer process as follows: § Clinic/personal clinician discontinues practice at a certified clinic; § Does certification transfer with the personal clinician when they change practices and need to establish a new care team; § When HCH certified clinic changes address or closes, does their HCH certification end; § When staffing changes reduce/dramatically change the composition of the previously approved care team/care coordination model at the certified clinic/personal clinician team. In 1-2009 as a part of the HCH Capacity Assessment, we noted that at least 10% of primary care practices changed addresses or closed/re-constituted as different entities from the preceding year. This indicates a need for a different step (other than "surrender") for previously HCH certified clinics and personal clinicians to reconstitute and continue their HCH model in a new location or with a new team.	Minnesota Chapter of the American Academy of Pediatrics, Anne Edwards, MD, President and Katherine Cairns, Executive Director	This is an administrative process.
313	3			Consider clarifying other reasons for surrendering the HCH certification or a transfer process as follows: § Clinic/personal clinician discontinues practice at a certified	Minnesota Dietetic Association Public Policy Committee, Stephanie	This is an administrative process.

**Health Care Homes Chart of Public Comment
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Rule Part 0070: Revocation, Reinstatement, and Surrender						
	Subpart	Letter	Line #	Questions, Comments, Concerns	Organization Name	Response
				<p>clinic; § Does certification transfer with the personal clinician when they change practices and need to establish a new care team; § When HCH certified clinic changes address or closes, does their HCH certification end; § When staffing changes reduce/dramatically change the composition of the previously approved care team/care coordination model at the certified clinic/personal clinician team. In 1-2009 as a part of the HCH Capacity Assessment, we noted that at least 10% of primary care practices changed addresses or closed/re-constituted as different entities from the preceding year. This indicates a need for a different step (other than "surrender") for previously HCH certified clinics and personal clinicians to reconstitute and continue their HCH model in a new location or with a new team.</p>	<p>Heim, RD and Katherine Cairns, MPH, RD</p>	