



Response Report for Review and Comment October 2009

BASKETS OF CARE OPERATIONS AND ADMINISTRATIVE CHALLENGES PHASE 2

GENERAL COMMENTS:

Comment #1:

Patient Engagement in Care: Regarding the reference to “shared decision making” – is the committee looking at the formal Dartmouth model of Shared Decision Making, or is your meaning in the document more of an informal, yet informative discussion between provider and patient? We would prefer the latter.

The committee agrees and is recommending the latter, a more informal, informative discussion between the patient and the provider. If an organization chose a more formal approach to shared decision making, this committee would support that also.

Benefit Design: Agree that medication should not be included in the basket design or price.

Several basket subcommittees support the inclusion of medications in their basket, expecting that this may improve patient outcomes. Pharmacy benefit design creates administrative and operational barriers to including medications in baskets currently. The committee supports creation of solutions to resolve these barriers in the future.

Data Portability & Integration: The meaning of this paragraph is unclear. Regarding Data Portability: we are not sure why Patient/Personal Health Record portability is in the scope of this initiative.

Use of PHR's could facilitate the sharing of patient information, particularly when an organization does not have an electronic record. This would make patient data very portable.

Measurable Outcomes: Why is it important to also provide a fee for service equivalent cost for the baskets? Are providers expected to provide/publish this along with their basket price? Also, who would be calculating into the “total cost of care” the non-medical costs, such as lost days of work, referenced in your example.

Fee for service cost is not required nor will it have to be posted with the basket price. This may be a beneficial piece of data, for comparison and to demonstrate ROI.

Miscellaneous: Agree with implementing Baskets in a phased manner, starting with acute care baskets.

We are concerned that the level of interest and probable participation anticipated statewide is very low and are hesitant to invest in our capacity to participate if this is a doomed initiative.

Comment #2:

We would like to reiterate that we still have several concerns with baskets of care, including their potential to fragment care, drive up administrative costs and create confusion in the market. However, we also believe that baskets could be a useful tool to create transparency for consumers, if implemented correctly. In addition to these preliminary concerns, we have numerous questions regarding the operational viability of baskets of care. For example:

- How will baskets be cross-walked against current CPT code billing to determine what falls within a basket and what is outside the parameter of the basket? Which are pieces of current CPT billing and which are not?

One “general code” will be used for ALL the components of a basket, a crosswalk of codes would not have to be done. This special code will have to be applied for. See Phase I Report for more detail.

- Who will determine how to code and bill for baskets?

Need MDH to seek approval for special codes. See Phase I

- How should payment occur when services rendered are beyond the parameters of a particular basket, or when services rendered are less than the basket?

Services rendered outside the basket components would be billed as fee for service. Providers will need to determine which basket components are appropriate for each patient. Some services are required for all patients and some are provided only as appropriate.

- Will a new coding methodology be built?

No new methodology will be required, just new “general” codes. In future new methodologies may be appropriate; we would encourage consideration of this.

- Are baskets for self-pay situations only? If not, then what is the estimated additional administrative cost to administer these baskets?

Baskets are not for self-pay patients only. The administrative costs will be different for each basket.

- What is the estimated medical savings that will be achieved?

It was intended and is expected to be a cost savings by improving quality long-term.

- Why do the measurement columns on the baskets have little information? If this is to be a new payment model, there should be financial measures and projections.

Financial measures and projections are out of the scope of the measurement subcommittee, they focused on quality and outcomes measures.

- Who will be tracking implementation?

We recommend this to be accomplished through a learning collaborative and sharing learnings of pilots.

- What if the baskets conflict with negotiated rates/billing groupings at plans?

There is not reconciliation between the two. It is a parallel process. Each health plan can choose if they want to offer the basket in contracts. Per the legislation, the basket rate is determined by the basket owner. Each organization has one price for their basket so no negotiation needed to create different basket prices for different purchasers. Keep in mind this is voluntary

- Is it an expectation that billed charges will be paid?

Anyone purchasing a basket from a particular organization will pay one price for all services rendered inside that basket.

- Is this truly a payment model or a guideline implementation model? Perhaps phase one should utilize baskets as a tool to measure guideline implementation. After mechanisms have been developed to measure and operationalize on that level, then phase two could include exploring feasibility of using baskets to pay claims.

This is both an evidence-based care delivery model with a payment mechanism. This model identifies best care and provides a payment structure to support the delivery of that care.

- How can we ensure baskets are not inflationary?

Market will drive the cost of the basket based on the value to the consumer.

- How do baskets conflict with or enhance the provider peer grouping efforts?

It is unclear at this time how the health reform activities support each other. The committee suggests all health reform activities will be coordinated and enhance one another.

- Is there any proof that the baskets concept will yield positive results?

There has been some national and local work with episodic care. Prometheus has shown some positive results but there is not extensive evidence. There are some indications that for some conditions, episodic care is efficient and effective.

- Category 6, entitled “Administrative Burdens” raises a number of problems with the administration of baskets, but does not provide any substantial solutions. How will these problems be addressed and who will be responsible for ensuring that these problems are solved?

The Phase I subcommittee offered claims and payment work flows. This committee recommends a collaborative learning process.

Comment #3:

On behalf of the Minnesota Hospital Association’s members, which include 148 hospitals and 17 health systems throughout Minnesota, as well as the patients and communities our members serve, I offer the following comments regarding the work groups draft Phase II Report.

The Minnesota Hospital Association (MHA) is committed to health care reform and playing an active, productive role in the development, implementation and refinement of delivery and payment system reforms, like the baskets of care initiative, that are aimed at improving patient care through improved quality and/or increased affordability of health care services. To that end, MHA has appreciated the opportunity to nominate representatives and participate in many of the other work groups addressing the baskets of care initiative. MHA applauds the Minnesota Department of Health (MDH) for its efforts to pull stakeholder groups together under extremely tight deadlines to keep this initiative moving forward.

However, the process leading to the development of baskets of care continues to raise concerns for our members. In particular, the timelines mandated by statute are proving to be too short to adequately address the implementation concerns identified and raised. Several critical issues remain unresolved and the initiative should not move forward on a full-scale basis before those barriers are overcome.

The timelines for implementation are not mandated. This is a voluntary program and thus a start date or participation is not required.

MHA supports the work group’s recommendations throughout the report that the state work with stakeholders to pursue pilot projects aimed at overcoming barriers, developing shared learning, and improving the viability of the baskets of care initiative before baskets are offered statewide in an uncoordinated way.

Patient engagement in care

MHA supports the work group’s conclusions that patient engagement is essential for the success of the baskets of care program. Also, MHA agrees that patients

need to know the “rules of the road,” specifically what services are included within and excluded from a particular basket.

As noted earlier, MHA believes the work group’s recommendation to pursue a pilot project to generate the data and experience needed to design the incentives for patients to seek out and choose baskets of care appropriately.

One concern, however, is that the work group’s recommendations, like so many aspects of this project, raises more questions than it answers. The report does not specify what kinds of patient incentives should be offered, whether those incentives would be standardized across plans, purchasers and providers or whether they would vary, how the incentives for getting “only the care they need” will account for additional care beyond the basket that their provider recommends or specifies because of the patient’s legitimate health needs, etc. These issues should be addressed and clarified so the stakeholders have a common understanding of their “rules of the road” in order to increase the chances that this effort improves patient care.

Detailed recommendations regarding incentives were not given to allow for flexibility and innovation. This is experimental and we learn what works well and adjust as we lean.

Patient volume

The report references “any certified providers” without defining that term. Does the work group anticipate a separate certification process for providers interested in offering a basket? If so, what type of certification process is anticipated? Instead, does it mean any “licensed provider” or some other certification standard?

Yes, we do mean licensed provider and have made that correction in the report.

The report also alludes to but does not describe constraints imposed by NCQA requirements. It would be helpful to explain those constraints and what, if any, alternatives the work group proposes for overcoming them.

There are regulatory reporting requirements for Hedis and NCQA, such as reporting of encounter data. The committee is recommending that Minnesota seek exemptions for these requirements.

Again, the work group encourages the state to move forward with a pilot project to develop solutions for concerns with generating sufficient patient volume. MHA supports this recommendation and urges the state to begin one or more pilot projects designed to develop and model different approaches to discern which are most advantageous for patients and the health care system.

MHA notes, however, that the work group’s recommendations fail to address previously raised issues associated with getting participation of Medicare and Medicaid patients and the lack of information for consumers to use to make decisions regarding baskets of care. Again, MHA encourages the state to

address and resolve these issues so that providers can move forward with assembling and offering baskets of care with a larger and more predictable patient volume than will otherwise exist if these questions remain unaddressed.

Benefit design

The report notes that some benefit designs are more appropriate for certain baskets, but it does not describe those benefit designs or explain why they “lend themselves to specific basket topics better than others.” Nor does the report offer recommendations or guidance as to what the state, purchasers or health plans should do with respect to this observation. Does the work group recommend changes to benefit designs? If so, what changes should be made? Should they be made to all benefit plans? Is legislation required to mandate benefit changes?

The Phase I identifies further detail about benefit design. Some benefit designs lend themselves to baskets of care because of cost sharing, benefits structures, variables in co-pay or co-insurance between services (i.e. high deductible plans, etc.). High deductible plans have very specific IRS rules about what services (illness vs. preventive) are subject to deductibles.

The report states that “a simple, straightforward . . . benefit design will facilitate patient acceptance of this . . . model,” but it fails to describe, define or otherwise guide stakeholders about what that benefit design consists of – what components make a benefit design too complex for patients otherwise interested in baskets of care? What are the features of a simple, straightforward benefit design that ensures that patients receive optimal care while also having incentives to pursue the efficiencies and quality improvements that might be possible through baskets of care?

We chose not to mandate a specific benefit design. A benefit design that recognizes a basket and co-insurance that is consistent across all services within the basket, will lend itself better.

The report includes a recommendation that medications be excluded from the baskets. How will this recommendation be integrated with the ongoing development of the individual baskets? Some MHA members have been following this initiative closely and are beginning to plan their own service offerings based in part on the scope of the various baskets. Questions have arisen as to who will resolve this contradiction between the recommended scope of the baskets and this report’s recommendations: the baskets steering committee, the individual baskets work groups, the Departments of Health and Human Services?

Several basket subcommittees support the inclusion of medications in their basket, expecting that this may improve patient outcomes. Pharmacy benefit design creates administrative and operational barriers to including medications in baskets currently. The committee supports creation of solutions to resolve these barriers in the future. Medications should be included if possible.

Data portability & integration

The draft report includes several conclusions: data needs to be portable, electronic medical records (EMRs) facilitate such portability but are not necessary, and personal health records may be useful. The report, however, fails to offer any underlying analysis, support or explanation for these conclusions.

Providers without EMRs may be relieved to learn that this lack of technology infrastructure is not impossible to overcome, but the absence of any explanation about how data portability will be achieved through other means leaves those providers without much basis to judge whether the process or effort they need to undertake makes offering a basket a viable, practical option.

The conclusion that this portability *can* be achieved is insufficient. Providers and payers need more information about *how* it can be achieved in order to assess whether the work group's conclusions are justified from a practical perspective.

Data portability is occurring now with the use of EMRs and PHRs or even paper. It is not as much a technical issue as a mind set, providers and patients must think about portability of data. This is a great opportunity for innovation.

Measurable outcomes

MHA strongly supports the work group's position to refrain from creating additional databases, more quality and experience measures. Such advice corresponds with the underlying goals of administrative simplification.

On the other hand, MHA has significant concerns about the work group's recommendations regarding cost measures. Instead of following parallel logic of avoiding additional administrative burdens and costs, the report lists an array of new cost data reporting and collection activities, including the collection of other costs such as the number of lost days of work. Reporting and collecting such disparate data would add new costs to the health care system for an initiative that is already in jeopardy of becoming cost additive (see e.g., Operational and Administrative Challenges Work Group Phase I report concluding that manual process and additional administrative burdens necessary for implementing baskets will increase costs for providers and payers). Accordingly, without further clarification that such cost data can be obtained without new reporting or administrative costs, MHA would urge the state to seek other means of assessing costs of baskets of care.

The "lost days" is just an example. To alleviate confusion, we have made a change in our report.

The report states that a control group is necessary for cost comparison purposes. The report does not specify whether the anticipated control group is a group of providers, patients, populations, etc.

Again, as with other elements of the report, the recommendations fail to address the entire list of issues identified as problematic and, therefore, MHA encourages the state to address those issues and develop resolutions before baskets are implemented

Administrative burden

This section of the report pertains to some of the most concerning issues raised in the Phase I report, but fails to offer or recommend solutions to those issues. Instead, the report concludes that a pilot project with collaboration among participants is necessary to work out the various administrative challenges that accompany baskets of care. So long as these critical issues and concerns remain unresolved, MHA supports the work group's recommendation to move forward with a pilot project designed for shared learning.

The work group also recognized the potential need of regulatory exemptions. MHA believes it is essential to identify which exemptions are needed and to secure those exemptions before this initiative is fully implemented. Otherwise, early adopters face greater exposure to regulatory investigations and actions as a result of unrealistic timetables for implementation.

We agree, this is consistent with our recommendations.

Actuarial risk

MHA remains concerned that the baskets of care initiative will result in additional costs to our health care system. In addition to the potential increased costs identified in the Phase I report, this report the need for resources to “accomplish the mitigation of risk associated with implementation of baskets of care.” The legislature did not appropriate money to mitigate these risks, which means the resources necessary will be in addition to resources already in the health care system. Unless or until a funding source is identified or reliable evidence indicates that baskets of care will save enough money to offset these additional costs, MHA suggests that the state move forward cautiously with this initiative to avoid the unintended consequence of increasing our health care costs.

Consumer opt in

MHA agrees with the work group's recommendations and observations.

Legal issues

Since the Transformation Task Force's initial draft recommendations, during legislative deliberations and throughout the baskets of care development process, MHA and other stakeholders have questioned the viability of baskets of care given existing federal laws and regulations, including those identified in the report. Despite these efforts, and now two draft reports from work groups tasked

with addressing these kinds of issues, the questions remain: how will providers work together to set prices and share revenues without violating federal Stark and anti-trust laws?

Legal issues are outside the scope of this committee.

The report again notes that these issues exist but offers no solutions other than a recommendation to create yet another group to look into these open questions. While MHA supports the recommendation, it is increasingly concerned that the state is leaving the most fundamental questions for the end of the process when there is the least amount of time and resources to adjust the initiative accordingly and still meet the statutory deadlines set by the legislature.

Miscellaneous

MHA agrees with the report's suggestion to implement baskets in phases and allow for lessons learned from the initial basket(s) to inform and guide the manner in which the health care community implements subsequent baskets.

However, MHA does not agree that the "acute care baskets" identified by the work group are necessarily the easiest or most feasible to implement initially. Instead, MHA suggests that the preventive care for adults and children and the OB-prenatal baskets are more feasible for initial adoption.

Some baskets appear easier to implement than others. There are practical realities that led the workgroup to recommend that the baskets should be implemented in phased manner to allow for consistency and capitalizing on the learnings, choose the easiest basket for initial roll-out and then progress to something more complex. The work group recognizes that the challenges vary based on perspective

First, unlike total knee replacement, the services in these other baskets are almost entirely offered by a single provider and the variation in costs and complexities of services are far less.

Likewise, unlike the acute low back basket, the triggering diagnosis or event that begins the baskets services are much more clear in these other baskets. Thus, it is easier for payers and providers to know when a patient has begun care that falls within a basket of care.

It is unlikely that the state will secure the necessary waivers or authorization to include Medicare patients in the baskets initiative. Several work groups and committees have identified the problems inherent in providers treating and billing groups of patients (e.g., non-basket-eligible Medicare beneficiaries) one-way and other patients (basket-eligible) a different way. Accordingly, it seems to make sense to focus on baskets that Medicare patients don't currently receive and that don't include medications: in other words, the preventive child care and OB-prenatal baskets.

By moving forward with these first, the state would allow for more time to secure Medicare's participation, and work out issues of medications and other complications associated with the other baskets. In the meantime, the private market is already moving forward with episode of care payment methodologies through the PROMETHEUS Project and other voluntary efforts. This strategy would give these efforts additional time to identify solutions and efficiencies before the other more complex baskets are rolled out.

Finally, if the state is going to consider precluding health care homes from offering baskets of care, as recommended by the report, it needs to communicate that recommendation to the primary care providers as soon as possible and provide stakeholders with an opportunity to comment before making a final decision. The health care home initiative is already moving forward with letters of intent from providers, some of whom may be operating under the impression that they would participate in both the health care home and baskets of care initiatives.

Furthermore, for MHA's members that provide a continuum of services from primary and preventive care to some of the most complex acute care available, there are significant implications to their planning for participation in these reforms if, at this late stage, the state is going to require that they choose to engage in health care home services or baskets of care but not both.

Again, just as Stark and anti-trust laws put a more significant barrier to participation in front of less integrated providers, precluding providers from offering both health care home services and baskets of care presents a greater restriction on more integrated systems. This unintended consequence alone – moving forward with health care home and baskets of care reforms that could result in creating disincentives for further care delivery system integration – could result in the need for significant re-thinking of the interrelated health care reforms enacted in 2008.

For those involved in developing those reforms, an implicit expectation was that the various initiatives would intersect, create compounding market incentives, and foster more collaboration and integration among providers. If the refinement of those reforms lead the state in a direction where the reforms must be undertaken in isolation from one another, where episode-of-care-providers need to ensure that they are structurally separate from health care home providers, or where operational complexities result in less automation and higher administrative costs, then it is incumbent upon the agencies and Health Care Reform Review Council to re-evaluate the direction taken and consider how to revamp the efforts to more closely align the legislative intent with the practical realities that have surfaced.

Provider engagement

Although it is curious that the report addresses provider engagement after all other topics, including "Miscellaneous" issues, MHA agrees with the work group's recognition of the need to mitigate providers' risk during the initial implementation of the baskets initiative. Given the various administrative complexities identified

even before baskets have been offered, it is reasonable to assume that a host of additional complexities, challenges and obstacles are yet to be discovered. If providers bear the risk of those unknowns as well as the risks associated with a new episode-of-care payment methodology, the initiative is unlikely to succeed.

MHA appreciates the opportunity to offer these comments and suggestions. If there are further questions or concerns arising from any of the issues we have addressed, please feel free to contact me anytime at (651) 659-1421.

Comment #4:

We agree that patient engagement is a critical challenge to overcome and the workgroup listed many possible solutions. The (4) most important factors we have learned in our work have been a perceived need by the patient, financial incentives, educational tools, and provider coaching and encouragement.

We understand the perspective of the workgroup on the complexity of medication benefit design, but believe having devices and medications as a 'buy up' option versus a separate purchase outside the basket might facilitate better adherence to medications. Adherence to medications is associated with better health outcomes in chronic diseases.

We agree that including medications may support better adherence to medication regimes. If this can be accomplished from the start, it should be done. Because of the complexities of pharmacy benefit designs and the variation in device purchasing costs, the committee suggested implementing "buy up" option in year two of the initiative. The committee is concerned that adding "buy up" options from the start may cause additional confusion.

We agree that Personal Health Records (PHR), if pre-populated with the patient's health information and relevant education, can facilitate patient engagement mentioned above.

We agree that baskets should be implemented in a phased approach. Although more complex, the workgroup should consider implementing a chronic disease earlier given chronic diseases are the primary cost driver in health care.