



Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900

phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

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Katie Burns
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Sent via e-mail to health.reform@state.mn.us and Katie.burns@state.mn.us

Dear Ms. Burns,

On behalf of the Minnesota Hospital Association's members, which include 147 hospitals and 17 health systems throughout Minnesota, I am honored to offer the following comments regarding the proposed baskets of care rule.

The Minnesota Hospital Association (MHA) is pleased to see that the proposed rule incorporates many of MHA's suggested improvements to the work group recommendations submitted earlier this year. By incorporating these suggestions, as well as ideas and recommendations put forward by other stakeholders, the proposed rule is significantly improved.

It is also important to express MHA's appreciation for the opportunity to have representatives from our membership serve on the baskets of care steering group and many of the work groups discussing the multitude of issues, ideas and questions that this initiative generated. Again, while MHA believes that further changes should be made before promulgating the final rule, we are confident that the active participation of stakeholders from across the health care industry helped make the proposed rule better and more reflective of the spirit of innovation that permeates our health care sector in Minnesota.

MHA supports the exploration of reforms designed to change the way health care is delivered and paid for in our communities. To that end, baskets, bundles or episodes of care offer some promise in fostering more care coordination across providers treating a single patient. As we have urged the legislators and state agencies, it is imperative that Minnesota create a statutory and regulatory framework for baskets of care that aligns with other state and federal reform initiatives.

Regardless of what the final rules contain when first promulgated, MHA encourages policymakers and administrative agencies leaders to quickly revise the rules when greater alignment with other initiatives can be achieved. In particular, MHA's members are concerned that Minnesota's eight "baskets" will differ from the "bundles" to be used in Medicare. Different procedures entirely is less concerning than different scopes for similar episodes. For example, a 90-day total knee replacement basket for a non-Medicare patient co-existing with a 30-day total knee replacement bundle for a Medicare patient threatens to create unnecessary administrative complexity, increase quality measurement confusion, and generate additional costs for patients

and providers. MHA hopes that the rules will be readily amended to realign with those promulgated by CMS so that Minnesota continues to leverage the benefits of uniformity and simplification.

The baskets of care, health care homes, provider peer grouping and quality measurement system initiatives have substantial overlap. Yet, it remains unclear how these areas of overlap are being leveraged for even greater system-wide improvement. Even more troubling, confusion remains about how these overlaps will function simultaneously with one another. MHA encourages the state to further clarify how per-member/per-month care coordination fees in the health care home model and single, episode-of care payments in the baskets of care initiative will co-exist. Can providers receive both payments, or does one preclude the other and, if so, which has precedence?

MHA understands that the enabling legislation mandates at least one basket for a chronic condition. Of all the chronic conditions, asthma care for children appears to be an appropriate selection. By their nature, however, chronic conditions are difficult to bracket chronologically and inevitably require treatment before, during and after any defined basket of services. This presents challenges for determining when a basket should start and end, as well as for measuring the quality of a provider's services since the true quality of care provided in one period of time might not emerge until a year or more passes.

It would be helpful for providers, payers and patients to have more guidance regarding enrollment in a basket of care. Presumably the patient retains the decision whether to "obtain" or "purchase" a basket of care. Can a patient in the midst of a course of treatment – say, for example, a diabetic – decide to enroll in a basket of care for that treatment mid-stream or is a patient precluded from participating in a basket of care unless he/she makes that decision at the onset of treatment? On the other hand, will providers and payers be allowed to use baskets of care as a back-office coverage and payment negotiation between themselves without patient involvement? In other words, a provider and insurer agree that its diabetic insureds who qualify for the basket of care will receive those services at the set price even though those patients never selected the basket for themselves?

Moreover, it would be helpful if the rules could clarify whether providers and payers of a basket of care are allowed to make the basket contingent upon the patient's agreement to and compliance with receiving care within the scope of the basket from that provider or providers to whom it referred the patient? Providers assuming the inherent financial risk associated with a basket of care should not be expected to bear that risk if the patient chooses to receive treatment from other providers that were not part of the basket. In other words, if the basket provider refers a patient to a high-quality, low-cost specialist for care within the basket and the patient decides to receive care from a higher cost, lower quality provider instead, the basket provider should not bear the financial or quality measure consequences resulting from the patient's decision.

MHA offers the following comments with respect to the individual aspects of the proposed rules:

Definitions

Part 4765.0020, subpt. 4, lines 2.8 and 2.9: MHA suggests adding “fewer or” after the word “includes” and before the word “additional,” and replacing “not” with “than those” after the word “outcome” and before the word “listed” so that collections of subsets of a basket cannot be marketed as a state-designated basket of care.

Duties of providers offering baskets of care

Part 4765.0030, subpt. 1A, lines 2.21 - .22: The enabling legislation states that a provider with an established price for a basket of care cannot vary the amount it accepts for payment in full “for a health care service based on the identity of a payer, upon a contractual relationship with a payer,” etc. *See* Minn. Stat. sec. 62U.05, subd. 2(b). However, the proposed rule would allow providers to offer a basket of care at an established price to “a payer” but not to “all payers.” This seems to contradict the legislation that explicitly requires a provider offering a basket of care to not vary the amount it will accept as payment in full based upon the identity of the payer or a contractual relationship with a payer. Thus, it seems impossible for a provider to offer a basket of care at an established price to one payer and, at the same time, not offer to accept the same amount as payment in full from other payers without violating the statute. MHA believes the Legislature intended to require basket-offering-providers to establish a single price that applied to all payers and to prohibit some providers and payers from working out their own, exclusive basket-pricing deals that were unavailable to patients insured by different health plans or group purchasing arrangements. MHA suggests that these lines be eliminated in the final rule.

Part 4765.0030, subpt. 1C(2), lines 3.6 - .7: The proposed rule uses the terms “relative or friend of the provider” without any definition or guidance for determining who qualifies as a relative or friend of a provider. Although MHA recognizes the difficulty inherent in defining such ambiguous terms in a manner that captures the varied and complex relationships in different communities, we believe leaving the terms undefined leaves them subject to arbitrary and capricious application in the future.

Part 4765.0030, subpt. 2, lines 3.8 - .14: MHA opposes the proposed registration requirements and urges the Department to delete this subpart to avoid making baskets of care more costly, burdensome and administratively onerous than necessary.

These bureaucratic requirements were neither required nor recommended by legislators or the participants in the more than ten work groups and steering committees addressing various aspects of the baskets of care initiative. After monitoring many of the work group and steering group meetings and reviewing the available minutes from those meetings, there is no evidence that requiring providers to register with the state was ever discussed, let alone recommended, by any of the participating stakeholders. Likewise, nothing in the enabling legislation requires provider registration. Nothing in the legislation or work group discussions references new obligations for providers to designate a “contact person” for a basket of care.

Providers interested in offering a basket of care will face additional administrative burdens and complexities associated with coding, billing and payment. They will be subjected to additional quality measurement reporting and evaluation. These registration requirements amount to additional costs, regulatory burdens and administrative hassle and will do little more than impose another impediment to innovation for providers interested in experimenting with new payment

and delivery models. Resources spent by providers and by the state to administer this new reporting system could be saved or better utilized elsewhere in the health care system.

Accordingly, MHA suggests that the department eliminate lines 3.8 through 3.14 in a final rule.

Asthma Care for Children (Appendix A)

It is understandable that the department did not want to specify what type of providers must deliver services within the basket and, instead, left the basket open to “licensed medical professionals.” However, it seems that some of the features should clarify and include specifications regarding consultation with a pulmonologist, coordination with a pediatrician or other appropriate providers with specialized knowledge to ensure that those providing this basket have some experience and/or expertise with providing appropriate, high-quality care to children with asthma.

The features of the basket include “Classify severity – as described in evidence-based guidelines” without defining or directing the public to which evidence-based guidelines. Presumably, the department intends for providers to classify severity based on recent guidelines, but nothing in the rule or appendix would prevent providers from using long-outdated guidelines, for example.

Many of the features include minimum numbers of services but do not specify a maximum number. This lack of specificity is problematic given the proposed rule’s admonition that “A collection of services that includes additional services . . . not listed in appendices A to H must not be identified as a state-designated basket of care.” *See* Proposed Rule 4765.0020, subpt. 4, lines 2.8 to 2.10. Providers offering this basket, with the features defined with minimum amounts of services, will likely deliver additional services than those listed and could face challenges that they are not eligible to claim to offer a state-designated basket. Moreover, by setting a floor without a ceiling on the amount of services to be delivered, the proposed rule will put providers at greater financial risk of pricing a basket before knowing the variations of needs of their patients.

Similarly, other features specify the frequency of services as “if needed.” “If needed” is not a standard that consumers or providers can understand clearly. Who determines when a home assessment is needed – the patient, the provider, the payer? Without an objective standard on which to assess whether a provider is delivering the care bargained for by the basket purchaser, the provider remains vulnerable to the ambiguity and challenges of failing to deliver the agreed upon services. Accordingly, MHA encourages the department to define when in-home monitoring will be provided in a basket of care or eliminate this feature.

The features include both spirometry and “peak-flow monitoring (consider when spirometry is not available)” (parenthetical original). For patients considering this basket, these alternatives are similar to a package label stating “batteries included, or consider an alternative power source if they are not included.”

MHA is pleased that the department revised the proposed rule to clarify that copies of the written action plan will be provided to families rather than earlier recommendations that appeared to require providers to deliver the action plan directly to schools without an opportunity for the patient or patient’s family to choose to whom the patient’s medical information is disclosed.

Medically Uncomplicated Type II Diabetes (Appendix B)

As MHA discussed in its earlier comments to the work group's recommendations, it is unclear whether the exclusionary conditions listed preclude a patient from falling within the scope of the basket if they are present before service/treatment begins or if a patient falls outside the scope of the basket if an exclusionary condition presents at any time, including after basket services or treatments are already under way. It would be helpful for providers preparing to offer this basket to know how the mid-basket occurrence of otherwise exclusionary conditions will be handled.

Moreover, MHA members expressed concerns about the four body system levels and potential addition of administrative burdens to implement a systematic assessment for determining "basket eligibility" in a clinical setting. Because MHA hopes to keep baskets as administratively accessible and cost effective, it encourages the department to consider a more streamlined and objective manner of describing which patients are eligible for this basket of care. On the other hand, if there is no efficient means by which providers will be able to distinguish eligible from ineligible patients for the basket, the department should reconsider whether to include Type II diabetes as one of the initial baskets of care offered in Minnesota.

Except for flu vaccination, all of the features include minimum numbers of services but do not specify a maximum number. This lack of specificity is problematic given the proposed rule's admonition that "A collection of services that includes additional services . . . not listed in appendices A to H must not be identified as a state-designated basket of care." *See* Proposed Rule 4765.0020, subpt. 4, lines 2.8 to 2.10. Providers offering this basket, with the features defined with minimum amounts of services, will likely deliver additional services than those listed and could face challenges that they are not eligible to claim to offer a state-designated basket. Moreover, by setting a floor without a ceiling on the amount of services to be delivered, the proposed rule will put providers at greater financial risk of pricing a basket before knowing the variations of needs of their patients.

MHA supports the proposed quality measures to the extent that they align with those collected and reported by Minnesota Community Measurement. This alignment reduces the amount of different or conflicting information for providers and patients. In addition, MHA believes that reducing reporting and administrative burdens on providers, especially the burdens and costs associated with reporting different quality measures for the same condition to multiple organizations, increases the time and resources providers are able to devote to patient care.

Prediabetes (Appendix C)

MHA suggests revising the scope of patients who are eligible for this basket of care to those who are 18 to 65 years of age. Because the vast majority of adult patients over age 65 are covered by Medicare, which is specifically excluded from baskets pricing under state and federal law, MHA believes that setting the upper age at 70 could create unnecessary confusion for providers and Medicare patients.

MHA also notes that many of the quality measures are far more dependent upon patient behavior than provider behavior. As a result, the proposed measures create the potential unintended consequence that providers will become more selective about which patients receive information about or encouragement to participate in this basket.

Low Back Pain (Appendix D)

MHA suggests revising the scope of patients who are eligible for this basket of care to those who are 18 to 65 years of age. Because the vast majority of adult patients over age 65 are covered by Medicare, which is specifically excluded from baskets pricing under state and federal law, MHA believes that leaving the upper age limit undefined could create unnecessary confusion for providers and Medicare patients.

Many of the features include minimum numbers of services but do not specify a maximum number. This lack of specificity is problematic given the proposed rule's admonition that "A collection of services that includes additional services . . . not listed in appendices A to H must not be identified as a state-designated basket of care." *See* Proposed Rule 4765.0020, subpt. 4, lines 2.8 to 2.10. Providers offering this basket, with the features defined with minimum amounts of services, will likely deliver additional services than those listed and could face challenges that they are not eligible to claim to offer a state-designated basket. Moreover, by setting a floor without a ceiling on the amount of services to be delivered, the proposed rule will put providers at greater financial risk of pricing a basket before knowing the variations of needs of their patients.

While MHA understands the reluctance to define which providers are eligible to offer baskets of care, it is important for the "Manipulation including assessment by a qualified provider" to include or refer to a definition of "qualified provider" for that service.

With respect to the quality measures, it seems that the Oswestry measure would need to be risk adjusted to account for varying degrees of mobility at the time the patient seeks care. At this time, however, MHA is unaware of a sufficient risk adjustment tool for such a measure.

Obstetric Care (Appendix E)

Other baskets' scopes include statements that medications, supplements, etc. are excluded from the basket. Because many components of this basket pertain to discussion of and advice regarding these items, MHA suggests a clarifying statement that prescriptions, over-the-counter medications, vitamins, herbal supplements, etc. are not within the scope of this basket.

In addition, it has been suggested that the basket of care be expanded to include a patient pre-labor and delivery class because it is similar to other prenatal services designed to improve the likelihood of successful delivery of a healthy baby and reduce complications.

Preventive Care for Adults (Appendix F)

MHA suggests revising the scope of patients who are eligible for this basket of care to those who are 18 to 65 years of age. Because the vast majority of adult patients over age 65 are covered by Medicare, which is specifically excluded from baskets pricing under state and federal law, MHA believes that setting the upper age at 75 could create unnecessary confusion for providers and Medicare patients.

The appendix lists several items under “Health Screening/Risk Assessment for:” without defining any of them. The single word “hearing” does not direct whether the service is a hearing screening and, if so, how elaborate, or whether the service is a risk assessment for hearing loss which could amount to little more than a questionnaire of hearing loss environmental factors. Does “vision” mean a full eye exam for glaucoma, retinal detachment, cataracts, etc., or is it sufficient for a physician to ask a patient if she has any problems with her eyes? Does “breast cancer screening” include a mammogram? MHA believes that further definition and description of the services and tests would help patients and providers better understand what is included and excluded from the basket.

It is unclear whether a patient who enrolls for this basket will receive the array of tests and screenings regardless of when the patient’s most recent screenings or tests were performed. In other words, is a patient who received a colorectal cancer screening 18 months ago required to be screened again when he signs up for the basket of care even though best practice guidelines call for such screening once every ten years? Likewise, because of the broad age range of patients eligible for the basket, it is possible that the basket could result in screenings or testing of patients who are not yet of an age when such screening is otherwise recommended or useful.

Preventive Care for Children (Appendix G)

The rule should allow for an exception to the breastfeeding promotion requirement for providers whose patients’ parents or caregivers are physically unable to breast feed, foster or adoptive parents, or other patients, etc.

Total Knee Replacement (Appendix H)

The timeframe/frequency designated throughout the basket is per patient or clinical requirements without any definition or standard on which prospective patients could compare providers. Likewise, because the proposed rule prohibits describing a set of services as a state-designated basket of care if the set “includes additional services . . . not listed in appendices A to H.” .” *See* Proposed Rule 4765.0020, subpt. 4, lines 2.8 to 2.10. Without any definition of either “physical therapy” or “per patient requirements,” it could be difficult for a prospective patient to assess which basket-offering provider will deliver the best value. Moreover, it is extremely difficult to determine whether a provider is offering “additional services” to those listed in appendix H for purposes of enforcing Proposed Rule 4765.0020, subpt. 4.

While MHA understands and supports the use of a 90-day window from a quality and reliability of outcomes perspective, it is apparent that the federal government is relying upon 30-day post-discharge timeframes in many of its reform initiatives, including bundling of payments in Medicare and expected readmissions payment policies. In order to maintain continuity, reduce

confusion of quality and cost data, and create as much uniformity as possible to best leverage the baskets of care initiative, MHA encourages the state to re-examine the 90-day timeframe if and when future quality and payment regulations pertaining to total knee replacement are developed by CMS.

Again, MHA appreciates the opportunity to provide these comments, ideas and suggestions on behalf of our hospital and health system members. We look forward to continuing to work with state agencies, consumers, employers and our colleagues throughout the health care sector to further refine, develop and improve upon the proposed rules so that the baskets of care initiative can be as successful as possible. If you have questions or would like additional clarification of any of our comments, please feel free to contact me anytime.

Sincerely,

Matthew L. Anderson