



Minnesota Hospital Association

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October 19, 2009

State Health Care Reform Update

Health Care Reform Review Steering Committee

*MHA Representatives: Deb Boardman, RiverView Health, Crookston,
Mark Eustis, Fairview Health Services, Minneapolis*

The Health Care Reform Review Steering Committee meets at least quarterly to review the state's progress toward implementation of payment reforms, price and quality transparency, and health care homes specified in the 2008 health care reform legislation. The bulk of the committee's time is spent reviewing presentations by the Departments of Health (MDH) and Human Services (DHS) regarding the timetables and discussions of the various work groups described below. At its meeting in June, the steering committee also discussed aspects of federal reform proposals to gain a better understanding of their potential impact on Minnesota's reform initiatives. Its September meeting included an update on reform initiatives and H1N1 flu projections and preparation efforts

Baskets of Care

One of the more provocative proposals in the 2008 health care reform bill calls for MDH to create a minimum of seven standard "baskets of care." In 2010, providers can begin offering one or more of the standard baskets of care on a voluntary basis.

The legislation does not provide much definition of a basket of care, but the concept of baskets of care seeks to bundle payments for a set of health care services delivered by one or more providers — for example, all of the services needed for knee replacement — together in a manner that creates financial incentives for those providers to cooperate with one another to hold down costs and improve outcomes for patients. Thus, instead of paying for each of the unbundled services separately, the legislation allows providers to offer the entire collection of services together as one "basket" with one bundled price.

The theory behind this legislation is that baskets (also referred to as packages or bundles) will make it easier for individuals to compare prices, thereby creating market incentives for providers to work together to decrease their costs so their basket price is more attractive. Today, a patient needing a knee replacement is unable to compare providers' costs without individually researching the estimated costs for diagnostic imaging, anesthesia, surgeon, medical device, equipment and supplies, hospitalization, rehabilitation, pharmaceuticals, etc. Under a basket of care, the state will establish a standard set of services that fall within a basket of care for knee replacement. A provider or group of providers choosing to offer that knee replacement basket will set its own non-negotiable price, and patients will be able to compare provider-to-provider based on their price and quality.

Baskets of Care Steering Committee

MHA Representatives: Carl Vaageness, St. Gabriel's Hospital, Little Falls

David Wessner, Park Nicollet Health Services, Minneapolis

Last January, the steering committee determined that the first seven baskets will be diabetes, asthma care for children, preventative care for adults, preventative care for children, obstetric care, low back pain, and total knee replacement. MDH then appointed subcommittees to develop recommendations for each basket's scope and services.

Each subcommittee met up to three times between February 16 and April 30. MDH finalized the baskets in July and will develop standard quality measures for each basket by the end of 2009. Through that process, the subcommittees recommended eight baskets: the original seven plus a new basket for prediabetes care. A general summary of the scope of each basket as defined to date is listed below with links to the subcommittee documents for further information:

Diabetes

Assessment, monitoring, and outpatient management of adults ages 18 to 65 years old with medically uncomplicated Type 2 diabetes, excluding those with advanced or end-stage diabetes-related complications, other severe conditions as specifically defined or pregnancy. At this time, this basket's scope does not include medication or supplies.

Subcommittee's report can be found at

http://www.health.state.mn.us/healthreform/baskets/Diabetes090604_Report.pdf.

Pre-Diabetes

Management of adults ages 18 to 70 years old with prediabetes, defined as: Impaired Fasting Glucose (IFG) [IFG=FPG 100 mg/dl (5.6 mmol/l) to 125 mg/dl (6.9 mmol/l)] or Impaired Glucose Tolerance (IGT) [IGT= 2-h plasma glucose 140 mg/dl (7.8 mmol/l) to 199 mg/dl (11.0 mmol/l)]. The basket would be provided over the course of one year and would include lab monitoring, management including weight loss and increased activity, and follow-up counseling. Subcommittee's report can be found at

http://www.health.state.mn.us/healthreform/baskets/Prediabetes090604_Report.pdf.

Asthma care for children

MHA Representative: Dr. Gail Brotzman, Hennepin County Medical Center, Minneapolis

Comprehensive ambulatory care for children ages 5 to 18 years, diagnosed with asthma. Care is provided by licensed medical professionals in one year and includes assessment, monitoring, education, control of environmental factors, medications and devices. Children with severe cardiovascular and/or chronic respiratory diseases are excluded from the basket. Subcommittee's report can be found at

http://www.health.state.mn.us/healthreform/baskets/Asthma090604_Report.pdf.

Preventive care for adults

Provide a comprehensive health assessment for adults ages 18 to 75 on an annual basis, and a summary report or plan of care that recommends screening maneuvers, preventive counseling, immunizations and appropriate referrals based on health risk, age and gender.

This recommended basket excludes the provision of care or treatment. Subcommittee report can be found at

http://www.health.state.mn.us/healthreform/baskets/adultpreventive090604_Report.pdf.

Preventive care for children

Clinical preventive services and health care maintenance for children from birth (after hospital discharge) up to but not including the second birthday. This basket of care is intended for preventive health care including immunizations. It is not intended for the diagnosis and treatment of an acute or chronic condition. Excluded from this basket is active management of any illness or diagnosis and treatment of any disease or condition. Subcommittee report can be found at

http://www.health.state.mn.us/healthreform/baskets/childrenpreventive090604_Report.pdf.

Obstetric care

MHA Representative: Meg Hasbrouck, Allina Hospitals & Clinics, Minneapolis

Services in this basket are provided by licensed health care professionals and include prenatal services provided to women with a confirmed, intrauterine pregnancy from the confirmation of pregnancy until the onset of obstetrical labor. Patients with high-risk pregnancies such as HIV, insulin dependent diabetes, and multiple gestations are excluded from the basket. Subcommittee report can be found at

http://www.health.state.mn.us/healthreform/baskets/obstetric090604_Report.pdf.

Low back pain

Comprehensive history and evaluation, followed by conservative treatment for adults ages 18 years and older with symptoms of low back pain that are either acute (0-6 weeks) or chronic with acute exacerbation of a previous episode, with or without radiculopathy. Continual assessment of outcome and treatment will occur during a six-week period from the time of the comprehensive history and evaluation. Exclusions from the basket may include Cauda Equina Syndrome, cancer of the spine, infection of the spine, spine or pelvic fracture, major trauma, major progressive neurological deficit, pregnancy, history of recent (six-month) spine surgery, and other medical conditions for immediate evaluation or treatment. The cost of any imaging, needle injections or medications is excluded from this basket. Subcommittee's report can be found at

http://www.health.state.mn.us/healthreform/baskets/LowBack090604_Report.pdf.

Total knee replacement

MHA Representative: Gordon Gablenz, Ridgeview Medical Center, Waconia

This basket of care is for adults between 18 and 64 years of age with a BMI of less than 35, and determined to have mild or no systemic disease, who are electing unilateral primary (first-time) total knee arthroplasty as recommended by orthopedic consultation. The basket ends 90 days after the procedure. Subcommittee report can be found at

http://www.health.state.mn.us/healthreform/baskets/TotalKnee090604_Report.pdf.

Baskets of Care: Operational & Administrative Challenges Phase I Work Group

MHA Representatives: Dr. Rahul Koranne, HealthEast Care System, St. Paul

Patrice Kuppe, Allina Hospitals & Clinics, Minneapolis

Recognizing difficulties and concerns about the administrative and operations issues associated with the baskets of care initiative prompted forming this work group. In its first phase, the group is examining reimbursement issues, particularly eligibility, billing, coding and claims challenges, and developing a plan to allow payment transactions for baskets of care with minimal administrative burdens. The group released a draft report in August identifying significant challenges to implementing baskets of care and concluded that during the first year, the billing and payment process would need to be done manually, thereby increasing administrative burdens and costs. The draft report can be found at

http://www.health.state.mn.us/healthreform/baskets/operationsphase1_DraftReport.pdf. To review MHA's comments, go to <http://www.mnhospitals.org/inc/data/docs/baskets-phaseI-opadmin.doc>.

Baskets of Care: Operational & Administrative Challenges Phase II Work Group

MHA Representatives: Andy McCoy, Fairview Health Services, Minneapolis

Michael Allen, Community Memorial Hospital, Winona

Based on the questions raised and conclusions reached by the Phase I work group, this group met two times and attempted to delve deeper into proposing solutions for challenges to implementation of baskets of care. The group's draft report was released in September. Many of the questions and issues identified by the Phase I report were not addressed in this Phase II report. The group will meet again on October 21 to review the comments received. The draft report can be found at http://www.health.state.mn.us/healthreform/baskets/operationsphase2_DraftReport.pdf. MHA's response to the draft report can be found at <http://www.mnhospitals.org/index/hcreform1>.

Baskets of Care: Communications Work Group

MHA Representative: Jan Hennings, MHA, St. Paul

This work group is charged with developing recommendations to MDH regarding the design of a health care provider outreach effort to educate relevant providers about the baskets of care. Considerations will include different approaches for reaching care delivery organizations in a timely, efficient, and effective manner.

Baskets of Care: Measurement Work Group

MHA Representative: Mark Sonneborn, MHA, St. Paul

This work group held its first meeting in June and will develop recommendations to MDH regarding a set of quality measures related to baskets of care. These measures will also be used, as appropriate, for provider peer grouping (see page 6).

Health Care Homes

The Legislature instructed the MDH and DHS to define a “health care home,” a new primary care delivery model; establish the standards or criteria for providers intending to become a health care home; and create a care coordination payment system for health care home providers. According to MDH, the health care home model is intended to improve primary care so that it is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.”

MDH awarded a contract to the Institute for Clinical Systems Improvement (ICSI) to develop goals or outcomes that health care homes should achieve. ICSI’s final recommendations for outcomes or goals, as well as a report on the “state of the art” of health care homes were released in January and can be found at <http://www.health.state.mn.us/healthreform/homes/index.html>. MHA’s comments to ICSI’s recommendations can be found at <http://www.mnhospitals.org/index/hcreform1>.

By July 1, 2009, the law required MDH and DHS to develop standards and criteria for providers to meet if they wish to become or remain a certified health care home and receive care coordination payments.

Health Care Home Standards Work Group

MHA Representatives: Dr. John Helfin, Lakewood Health System, Staples

Dr. Thomas Patnoe, SMDC Health System & Duluth Clinic

ICSI’s draft outcomes were used by the 55-member health care home standards work group to guide its efforts to define the criteria or standards providers must meet to become and remain a health care home. In the end, the work group proposed dozens of standards and criteria for MDH’s consideration.

MDH and DHS took the results from the work group under advisement, prepared a draft rule and accepted comments from stakeholders. MHA’s comments on the departments’ draft rule can be found at <http://www.mnhospitals.org/index/hcreform1>.

Although the statute requires the rule to be in place as of July 1, the departments were unable to meet that deadline. Instead, they released a proposed rule on July 6 and, under the expedited rulemaking process, received public comments through August 6. MHA’s comments to the proposed rule can be found at <http://www.mnhospitals.org/index/hcreform1>. As of October 18, the final rule has not been promulgated.

Health Care Home Readiness Assessment

Under contract with the state, a consortium is in process of completing a readiness assessment for the health care home initiative. The consortium is made up of Stratis Health, the Minnesota Academy of Pediatrics Foundation, the Minnesota Academy of Family Physicians and the Minnesota Chapter of the American College of Physicians.

The consortium will complete assessments of the readiness of the primary health care delivery system to implement health care homes and of consumers’ understanding and readiness for the implementation of health care homes. As part of this assessment, the consortium surveyed more than 700 primary care clinics and received a 53% response rate. A copy of the survey can be found at <http://www.health.state.mn.us/healthreform/homes/ClinicSurvey.pdf>.

Based on its assessment research, the consortium will make recommendations to guide capacity building efforts to support the health care home initiative. The results of the assessment, survey, and recommendations are expected to be released later in August.

Health Care Home Payment Methodology Steering Committee

MHA Representative: Dr. Rahul Koranne, HealthEast Care System, St. Paul

This steering committee will help DHS and MDH create a system of per-person care coordination payments that will be paid to certified health care homes for qualifying patients. More specifically, the steering committee will receive input and advice from three subgroups (see below) and provide strategic direction on the development of the payment methodology. At this time, MHA expects the payment methodology to resemble a per-member/per-month payment for state health care program enrollees with chronic illnesses or multiple complex conditions.

Health Care Home Payment Methodology: Clinic & Payer Communication Processes Subgroup

MHA Representative: Patrice Kuppe, Allina Hospitals & Clinics

This subgroup has not begun to meet, but is tasked with evaluating and making recommendations to clinics on how to prospectively identify and designate health care home patients eligible for care coordination payments; developing a process whereby a health care home alerts the payer that a patient qualifies for care coordination payments; identifying the billing cycle duration for health care home services consistent with CMS and legislative requirements; and making recommendations for standardized coding and billing that meets the requirements of the Administrative Uniformity Committee (AUC).

Health Care Home Payment Methodology: Patient Risk Stratification Models and Methods for Minnesota Health Care Program Rate Development Subgroup

MHA Representative: Dr. Rahul Koranne, HealthEast Care System (co-chair), St. Paul

This subgroup has not begun to meet, but is tasked with defining the clinic work and processes that are included for payment in the care coordination payment; identify the patient information that is collected for payers to assign a rate used for risk stratification; and define the number of categories and the inclusion criteria for each category for patients that are eligible for care coordination payments.

Health Care Home Payment Methodology: Consumer / Patient Payment Considerations

This subgroup has not begun to meet, but is tasked with making recommendations on care coordination payments' effects on patient/member financial liability for the entire market; taking into account impact on consumers' out-of-pocket exposure to pass through of care coordination payments; and recommending strategies to respond to consumer concerns about information collected by providers and payers.

Health Care Home Learning Collaborative

Wilder Research, Jane Taylor, Ed.D, and Susanne Salem-Schatz, Sc.D. are under contract with MDH to research and evaluate collaborative learning methods and models that incorporate quality improvement approaches. This research will be used to foster statewide implementation of a health care home learning collaborative and to guide MDH for setting health care home certification requirements for providers. Specifically, the researchers will identify, document, and evaluate the effectiveness of models of collaborative adult learning and system improvement; recommend methods for implementation of health care home collaborative learning models; and recommend a plan to evaluate the effectiveness of such collaborative learning models.

Provider Peer Grouping

A controversial aspect of the 2008 reform bill calls for MDH to collect all price and encounter-level data from health plans and then use that information to determine providers' total relative cost of care. In other words, MDH will peer group providers under yet-to-be-determined criteria and allow for direct provider-to-provider comparisons by the public based on each provider's overall risk-adjusted cost of providing care. To begin the implementation process, MDH awarded a contract to the Maine Health Information Center to create a database into which Minnesota health plans must report all of their encounter-level data every six months. The rulemaking for this new reporting requirement was completed on July 6.

Meanwhile, MDH must create the analytical process to create a single, composite score of providers' cost and quality which will become publicly available on a Web site beginning in September 2010.

Provider Peer Grouping Advisory Group

MHA Representatives: Keith Harvey, Virginia Regional Medical Center

David Wessner, Park Nicollet Health Service, Minneapolis

This advisory group is tasked with developing the analytical framework and methodology for comparing providers, including hospitals and clinics, based on both quality and cost. The quality calculation will be based on standardized quality measures (see discussion below) and the encounter-level data received from health plans (see discussion above). At this time, the advisory group appears to favor grouping all hospitals together in a single peer group for comparison on the future Web site.

Based on this advisory group's work, MDH will contract with a vendor to perform the analytical work using the database of encounter-level data created by the Maine Health Information Center.

MHA's members have raised concerns about the peer grouping process. In general, members are concerned about the process of comparing hospitals and health systems with significantly different services, patient demographics, payer mixes and community needs under a single composite metric. In addition, members have raised concerns about calculating providers' costs of care without including costs of uncompensated care or costs of care delivered to non-Minnesota residents.

MHA's representatives on the work group have urged the group to recommend changes to the legislation requiring a single, composite score for cost and quality and, instead, to allow the public peer grouping Web site to use scatter-plot or other multi-indicator representations. Other suggestions from the advisory group include amending the legislation to allow the state to use encounter-level data gathered by the Maine Health Information Center for research purposes.

MDH created several issue papers as background for each meeting of the advisory group. Those papers can be found at <http://www.health.state.mn.us/healthreform/peer/issuepapers.html>. The advisory group's recommendations are expected to be released by the end of October.

Provider Peer Grouping Technical Panel

MHA Representative: Meg Hasbrouck, Allina Hospitals & Clinics, Minneapolis

This panel provides research and analytical support for the advisory group. In particular, it provides recommendations regarding the feasibility of various kinds of analysis, availability of necessary data, and statistical reliability of methodology outcomes to measure provider performance.

Quality Measures & Incentive Payments

The 2008 reform bill instructed MDH to create a uniform, standard set of quality measures that would apply to hospitals and clinics. Once implemented, the statute prohibits health plans from requiring providers to use or report any different measures.

In addition, the legislation called for the creation of quality incentive payments based on a subset of those quality measures. These incentive payments will be in addition to payments providers already received.

MDH awarded a three-year contract to a coalition of Minnesota health care stakeholders to inventory all existing quality measures, recommend a set of measures for Minnesota's standard set, and propose a quality incentive payment system. Minnesota Community Measurement is the primary contractor on behalf of the coalition that includes MHA, as well as the Minnesota Medical Association, Stratis Health, the University of Minnesota, and the Buyers Health Care Action Group. MHA's role is to lead the development of hospital quality measures and payment incentive program.

MHA's initial recommendations put forth quality measures that rely upon information hospitals already report. Consequently, hospitals will not suffer from new administrative burdens associated with this initiative. In August, MDH released a draft of proposed rules to implement the first set of quality measures and payment incentives. A two-page guide and the draft rules can be found at <http://www.health.state.mn.us/healthreform/measurement/drafrule.html>.

Meanwhile, MHA and its partners in the collaborative have moved on to the second phase of the project: defining more rural-relevant quality measures and payment incentives.

Hospital Quality Steering Committee

*MHA Representatives: Mary Ellen Bennett, Hennepin County Medical Center, Minneapolis
Solveig Dittmans, Regina Medical Center, Hastings
Bonnie Groneberg, St. Joseph's Medical Center, Brainerd
Margaret Kalina, Douglas County Hospital, Alexandria
Tammy LaFavor-Plowman, St. Mary's Medical Center, Duluth
Dr. Thomas Schmidt, Park Nicollet Health Services, Minneapolis
Nancy Wolf, St. Francis Regional Medical Center, Shakopee*

This work group provides advice and community input for which hospital quality measures should be collected and publicly reported, and which of these should be used for payment incentive programs.

State Health Improvement Program

The 2008 reform bill allocated \$47 million over two years from the Health Care Access Fund to finance grants for local public health initiatives aimed at reducing obesity and tobacco use.

MDH sought proposals from community health boards and tribal governments to create and implement policies, systems and interventions in schools, work sites, health care organizations, and other community organizations. MDH awarded grants to 52 community health boards and 11 tribal governments; every community that applied received funding under the program.

Grantees will create community action plans, assemble community leadership teams, establish partnerships with one another and community stakeholders, and implement and evaluate interventions to reduce tobacco use and/or obesity rates.

Essential Benefit Set

Essential Benefit Set Advisory Group

*MHA Representatives: Mary Maertens, Avera Marshall Regional Medical Center, Marshall
Bob Stevens, Ridgeview Medical Center, Waconia*

According to the 2008 legislation, the group will develop recommendations for private insurance plans to design benefit sets that encourages enrollees to use clinically and cost-effective services and use less ineffective or high-cost services. The Legislature's intent for this study was to develop recommendations for the design of an insurance benefit set that provides lower consumer cost-sharing for coverage for a broad scope of services based on scientific evidence demonstrating clinical and cost effectiveness. The legislation requires that the benefit set include necessary evidence-based services, procedures, tests and technologies that are clinically and cost effective.

Even before making recommendations, the work group requested public input regarding its work. MHA's comments can be found at <http://www.mnhospitals.org/inc/data/pdfs/comments-essential-benefit-set.pdf>.

The work group held six meetings and was due to submit its report by October 15. It is expected to release a draft of its report to MDH by the end of November. Then, MDH must obtain actuarial services to estimate the cost of a health plan that offered the essential benefit set and complete a final report by January 15, 2010.

Work Force Shortage Study

According to the 2008 legislation, MDH was required to consult with the health licensing boards and professional associations to study "changes necessary in health professional licensure and regulation to ensure full utilization of advanced practice registered nurses, physician assistants, and other licensed health care professionals in the health care home and primary care delivery system." As a result of this study, last January MDH made recommendations to the Legislature regarding changes to certain professional licensing and scope of work regulations. The final report, including recommendations, can be found at <http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf>.

Uniform Claims Review Process Study

The 2008 legislation requires MDH to "establish a work group including representatives of the Minnesota Hospital Association, Minnesota Medical Association, and Minnesota Council of Health Plans to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers."

Uniform Claims Review Work Group

MHA Representative: Joe Schindler, Minnesota Hospital Association, St. Paul

The work group must complete its study and make recommendations, including specific action steps necessary to accomplish each of the recommendations, by Jan. 1, 2010. This group has primarily focused on the next levels of administrative simplification. Two meetings were devoted to identifying issues associated with uniform pricing. More information regarding the work group can be found at <http://www.health.state.mn.us/healthreform/claims/index.html>.