This is a very innovative basket of care and is perhaps the best example of how innovation in payment policy could improve care outcomes. The inclusion of drugs, devices and durable medical equipment, as well as a home assessment and care coordination, in this basket represents a bold step forward in improving care of chronic disease by making sure that patients will have access to all needed diagnostic, care coordination and treatment requirements for their asthma. In many respects, this basket should be a model for all chronic care baskets or bundles that might be developed in the future.

Thank you for your supportive comments.

Scope:

1. Why aren’t younger children included (with an exception for spirometry). The EPR-3 makes specific recommendations for this age group.

   Thank you for your question. The subcommittee discussed the age range at their first meeting and agreed that including children under the age 5 would add a new dimension to the basket and it would be too complicated for our first effort.

2. Need to define who an “asthmatic” is, and which level of asthmatic receives which services.
   Any child with a clinician diagnosis of asthma is a potential candidate.

3. Overall, the scope and components are too broad by not containing language or elements restricting the care to that related to asthma. In addition, the scope and components are not defined enough and, consequently, allow for extreme or almost limitless variation in the amount of services a provider could offer under the basket rubric. As a result, while the work group’s recommendations are admirable given its limited opportunity to deliberate, they fail to accomplish the underlying goal of the baskets initiative: allowing consumers to compare providers’ cost and quality on a standard, defined set of services.

   A general objective of the baskets of care concept is to encourage providers, payers, and consumers to think differently about health care service delivery. While the health care system currently pays for services on a per-service basis, baskets of care are intended to offer health care providers an incentive to be innovative in providing a given package of services in a way that supports effective, high quality, lower-cost care. While there needs to be enough clarity or definition to allow for pricing as well as comparison, we have tried to offer parameters without being too dictatorial so that providers can be innovative in the implementation by meeting patient needs creatively.
It was the intent of the workgroup to define the frame and scope of work to be restricted to Asthma care and management of this chronic condition. For example, only those children who have a diagnosis of asthma will be included. Additionally, for the health assessment component - it is intended that this assessment be as applicable for those concerns/ issues pertinent for the patient with asthma and not include all potential preventive services.

4. “Comprehensive ambulatory care for children ages 5 to 18 years, diagnosed with asthma” encompasses a far greater scope of care than that associated with asthma. Comprehensive ambulatory care implies the provision all clinical care for children with asthma regardless of whether the care is related to asthma. Thus, the scope of the basket would include immunizations, strep throat tests, stitches, poison ivy treatments, etc. As a result, the recommendations morph the basket into something more similar to a boutique health care home.

Instead, the Minnesota Hospital Association believed that the basket of care would be limited to asthma-related services and treatments and, therefore, the scope of care would likewise be limited in a manner such as “Comprehensive asthma-related ambulatory care . . .” or “Comprehensive asthma treatment and services, other than emergency or inpatient services, for children . . .” Somehow the scope should modify and limit the care, services and treatments to those related to asthma rather than leaving the care as comprehensive and limiting only the scope of patients to those with asthma.

Thank you for your comments. The definition in the scope has changed to reflect your suggestion.

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

Our patients deserve to have priority given to strategies that have been studied and proven effective included in the asthma basket of care. Therefore, I submit the critically overlooked fact that medical homes and the asthma basket of care should ensure that patients with MODERATE to SEVERE asthma are referred to an asthma specialist (Allergist, Pulmonologist). Specialist care has been well studied and overwhelmingly proven to improve quality and decrease cost of care 1,2,3. This recommendation is in the NHLBI asthma guidelines as follows: Referral to an asthma specialist for consultation or comanagement of the patient is recommended if there are difficulties achieving or maintaining control of asthma; if additional education is needed to improve adherence; if the patient requires step 4 care or higher (step 3 care or higher for children 0–4 years of age); or if the patient has had an exacerbation requiring hospitalization. Consider referral if a patient requires step 3 care
(step 2 care for children 0–4 years of age) or if additional testing for the role of allergy is indicated (Evidence D).


Thank you for your comments. We agree that asthma patients who are consistently out of control (approximately 15-20% of children with asthma) need the services provided by a pulmonologist and/or allergist. This has been added to the list of components.

Components:

Assessment and Monitoring

6. Nowhere in this “basket” of care are there explicit recommendations for checking symptom frequency, so please make this more directive. Assessing symptom frequency (and spirometry) are the cornerstones of the most recent NHLBI/NAEPP guidelines in assessing level of impairment and control. The basket of care components mention checking ENT, Lung/heart exam, but the reality is that the physical exam is essentially almost always normal on a follow-up visit. What really needs to be done more frequently is assessing symptom frequency, per the first 4 rows of Figures 12/15 of the NHLBI/NAEPP Summary and NHLBI/NAEPP Summary page 16, indicating “assess control to adjust therapy”. Please make assessing symptom frequency more prominent in the “basket” of care.

Thank you. We agree. Assessing signs and symptoms of asthma is an integral part of assessing asthma control, and has been listed along with other inclusions for that component.

Thus, in summary, please do not require that all “basket” items be office or visit-based with a twice a year frequency on all “asthmatics” especially without defining who this population of asthmatics really is. Please also make a stronger emphasis on assessing asthma symptom frequency and spirometry to assess the level of asthma control (as opposed to an emphasis on physical exam), interpreting symptom frequency and any spirometry per national guidelines. (each answered separately)

7. The frequency contains a minimum but no other limits or standards. One provider could price the basket and provide the service once, whereas another provider could include multiple services. The consumer would have no way to compare the prices between the providers because the quantity of services is different.

The consumer and provider would together discuss what components and frequency is best for the patient. This may be determined by the severity and level of control of asthma. Then choose the basket that fits his/her needs.
8. I see no discussion of adherence assessment yet adherence is the largest single reason for lack of control.

   Thank you. **Assessment of adherence has been added to the list of inclusions in assessing asthma control. It is also be part of the education about medications**

9. Assess Looks good, but may need changes when MA and PMAP are added.

   **At this time, government funded health care is not participating in the baskets of care.**

10. Written asthma action plan is probably the more important part of this component.

   **We agree.**

11. Should be part of original (baseline) data so all assessments include physical, emotional, psychological, etc.

   **We agree.**

12. 6 month checks are appropriate for most groups. Would consider 12 month checks only for exercise induced with normal spirometry in the office on no daily meds.

   **We agree.**

   **Classify Severity**

13. Asthma severity varies often with seasonal changes whether due to allergies or viral illnesses in the community. Therefore, asthma severity might change more than once per year.

   **Thank you for your comment. Discussion of seasonal changes and documenting a patient’s symptoms is part of monitoring asthma control.**

14. If patients are already diagnosed and on a controller from another provider, severity classification is difficult. *(NAEPP-EPR-3)*

   **We agree**

15. Consider including a phrase to encourage classification per NHLBI/NAEPP guidelines

   **Thank you. This has been added to the component.**

   **Assess Control (Height/growth curve, ENT, lung/heart exam)**
16. It is hard to argue that those children with “intermittent” asthma really medically need twice a year height checks, as they are not on medications like inhaled corticosteroids that might impact growth and should not have asthma severity that should affect growth. Thus, it will be hard to convince families (and many providers) of the merit of office visits twice a year for height checks, when they feel that asthma is under good control. I feel that twice a year office visits in this group of “intermittent” asthmatics will be very hard to obtain, and its importance is not well supported by NHLBI/NAEPP guidelines.

*Thank you for your comment. The consumer and provider would together discuss what components and frequency is best for the patient. This will most likely be determined by the severity and level of asthma control. A general objective of the baskets of care concept is to encourage providers, payers, and consumers to think differently about health care services and how they are delivered. For example, for the patient in good asthma control, a ‘visit’ may be accomplished by a phone call or an e-visit.*

17. These guidelines recommend follow-up and monitoring, and this could be done as non-visit care and should be adjusted for level of asthma severity (as opposed to universal recommendation for all “asthmatics”). NHLBI/NAEPP summary page 34.” To maintain control of asthma, regular follow-up contact is essential because asthma often varies over time. Schedule pt contact at 1-6 month intervals, the interval will depend on such factors as the level or duration of asthma control and the level of treatment required.” Twice a year office visits for all asthmatics, regardless of asthma severity, would drive extra office-based health care utilization. It is also not likely an obtainable outcome/goal that will realistically happen in the “real-world” scenario. Please do not base compensation on the number of office visits, but instead on the attempt to gather the type of information needed to ensure good asthma care.

*Thank you. We agree.*

18. Should be at *every visit* (other than initial visit). Should include a validated questionnaire such as Asthma Control Test. *(NAEPP-EPR-3)*

19. Please consider rephrasing this to “Assess symptom control at least 2 times a year. More often if asthma is not under good control, per national guidelines”. *(NHLBI/NAEPP Figures 12 and 15)*

#18 & #19 *Thank you for your comments. The component, ‘Assess Asthma Control’ includes assessing symptoms. This should occur at a minimum two times a year. The suggestion to use a validated questionnaire such as the Asthma Control Test has been added as a tool the provider could use.*

20. Assess Control: Consider deleting (height/growth curve, ENT, lung heart exam)
Instead add use standardized asthma control test or questionnaire and personal interview. Standardized test will allow for comparison over time. Help determine if interventions are helpful. Face to face discussion is important for clarification/validation.

*Thank you. This has been changed*

21. Should include medication use, sx control, rule of 2’s and should be done at each visit *(NHLBI guidelines)*

   *We agree*

**Spirometry**

22. “minimum once” – does that mean once ever or once/year. For any persistent asthma should be once/year although EPR-3 allows for every 2 years for stable patients. May need more frequently for reasons also stipulated in EPR, e.g. prolonged periods of loss of control, step-up, step-down, etc..

23. I was not sure how to interpret this. Does this mean spirometry once ever, or spirometry required every year?

   NHLBI/NAEPP Summary page 18, “Use spirometry to obtain objective measures of lung function … Perform spirometry at the following times: at initial assessment, after treatment is initiated … and stabilized, during periods of progressive or prolonged loss of asthma control, and at least every 1-2 yrs, more frequently depending on response to therapy.”

   ICSI page 19 reiterates the same as above and page 9 says “follow-up spirometry every 1-2 yrs in mild asthmatics will reconfirm the diagnosis and objectify serial change and level of control. More frequent monitoring should be considered for the moderate and severe asthmatics.”

   Again, I was not sure how to interpret the “once” requirement for spirometry. Spirometry is of course a much stronger focus in the most recent national guidelines. It is likely not feasible to justify a yearly “requirement” for all the intermittent asthmatics.

24. Including more clear verbiage about spirometry performance to be done at least at initial diagnosis and at least every 1-2 years (depending on level of asthma control) may remind, encourage and give stronger incentive to more providers and more patients of the real merit and rationale behind obtaining an objective measure of asthma impairment and assessment for the risk for future exacerbations. *(NHLBI/NAEPP summary page 18, ICSI page 9 and 19)*

25. Spirometry: add with exacerbations. Treatment options might vary depending on spirometry results.
Thank you for your comments. On average, Spirometry should be performed once per year; that is reflected in the components of the basket. At this time there is not strong evidence that more frequent testing improves outcomes although FEV1 measurement helps predict risk of exacerbations.

Peak-Flow Monitoring (when spirometry not available)

26. Also, it is confusing to state that this component is required once and then state in the next component that peak-flow monitoring is required when spirometry is not available. This implies that a provider could offer the asthma care for children basket without providing this component. If that is the intent of the recommendation, then it should clarify that spirometry is not a required component of the basket. If, on the other hand, spirometry is required within the basket, then peak-flow monitoring should be rephrased to avoid this confusion.

27. Peak flow monitoring lags often behind symptoms and severity, more accurate to obtain Spirometry. Our office has ceased peak flow for just this reason.

28. Results are highly variable depending on the experience and training of the provider (ATS guidelines for PFT’s)

29. Peak flow meters are invalid in asthmatics that also have vocal cord dysfunction.

30. The focus in NHLBI/NAEPP for peak flow use is the management of exacerbations as part of the Asthma Action Plan. There are quite a few limitations of peak flow use, so it is hard to justify its use in this way as requirement in the basket of care.

   a. NHLBI/NAEPP Summary page 16 “Either symptom or peak flow monitoring is appropriate for most patients; evidence suggests the benefit are similar. Consider daily-peak flow monitoring for patients who have moderate or severe asthma, patients who have a history of severe exacerbations, and patients who poorly perceive airway obstruction and worsening asthma.”


Thank you for your comments. We have added the word CONSIDER to the Peak Flow component.

Medical Assessment
33. Medical Assessment: consider changing to Health Assessment if it will be done by someone other than a doctor. Would a NP or C-AE be able to do a “medical assessment”? Is it in their scope of practice?

   The medical assessment does not have to be done by an MD. Nurses are part of the medical team.

Home Assessment

34. Most insurance companies do not reimburse for home evaluations other than verbal reporting which usually erroneous (e.g. parents deny smoke or pet exposure).

   Thank you. To our knowledge in-home evaluations for environmental triggers is currently a ‘covered’ expense. And, it is a component that is included in the proposed basket of care.

   The basket of care workgroups were encouraged to think innovatively and not be limited to our current system of care. Also, the baskets of care workgroups, in their design efforts, worked hard to reflect a health care system that can be designed to give high quality care, all the time, in the right place. Given this, some components may not be a covered benefit within our current system of care – but were considered necessary by the workgroup.

35. “When 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?

   Allowing for an unlimited amount of any service places greater risk on providers offering the basket. Unless the work group can recommend a more objective, concrete amount of home assessment services, home assessments should remain on a fee-for-service basis outside of the basket.

   The frequency of the In-home assessment has been clarified. It should be done for asthmatics who are consistently poorly controlled.

Education (culturally and developmentally appropriate)

36. Education provided should be from an individual with extensive asthma background or knowledge, preferable a certified asthma educator.

   We agree and have clarified that asthma education should be performed by a Certified Asthma Educator.

37. I’m in strong support of the key care components specified in the basket of care. As a public health nurse and asthma educator, I feel asthma education is essential and needs to
be addressed frequently on a personal level to help assure compliance with recommended treatments and better outcomes. I would recommend at least 2 – 4 in home asthma education visits/6 months and in the clinic 2 initial sessions and additional sessions as needed for asthma exacerbations. Well worth the cost. Learning is a process, there’s a lot of new information to comprehend for the caregiver and person with asthma. Whenever the course of treatment changes more education is needed. Asthma is a condition that can worsen quickly and become life threatening when people are ill informed.

Thank you for your supportive comments

I agree its essential that families, clinics, school personnel, medical and clinic personnel are knowledgeable about the use of medication and medication delivery devices. I too feel that holding chambers are vital to ensure accurate medication delivery. Often clients are sent home from the clinic not knowing how to use their medication delivery devices. A return demo would be important.

Thank you for your supportive comments

38. Include phone triage and education; certification as an asthma educator should be a requirement. The time and cost is minimal.

Thank you – your comments are reflected in our current proposed basket of care

39. Who would be able to educate clients about asthma? C-AE, asthma educators, public health nurses, respiratory therapists, clinic RNs, NPs, health educators? What are training requirements for an asthma educator – especially if not certified asthma educator?

The subcommittee strongly agrees that asthma education should be performed by a C-AE. This is a goal that is achievable even in rural areas.

40. How specific does the education documentation need to be? Is it enough to document “discussed physiology of asthma with patient and parent” or will we need to document every bullet point under “basic facts about asthma”? Same goes for the section on medications, trigger control, patient skills (i.e. is it enough to document “inhaler technique discussed and demonstrated and patient/parent demonstrates knowledge and correct use and care of devices”?).

Thank you. The details of the components for quality asthma education have been listed. The baskets of care reform project will include a provision for the measurement of quality provided to the consumer. It is expected that asthma education would be documented in the medical record according to the components in the basket.

41. Does it need to be specified as to where education would take place (home, school, clinic, hospital)?
The Baskets of Care project encourages innovations to care delivery. Asthma Education should be available in a variety of locations using creative modes of delivery; such as phone, e-mail, face-to-face visits, etc. Schools should have trained asthma educators. Inhaler technique could be taught and assessed each time the patient comes to the clinic for a visit. An MD, C-AE (Nurse or Pharmacist) could do this.

Written Asthma Action Plan (copies sent to families, school: standardized form when possible)

42. Would an electronic care plan be available to all team members?

That is a great idea.

43. Consider adding “daycare/preschool” to copies sent to (for children < elem. school age)

44. Requiring copies of the action plan be sent to schools means that a patient cannot purchase the basket of care and refuse to disclose medical information to the school. Instead, the component language should be changed to be more patient-centered and require the provider to send copies of the action plan to the families and up to three other recipients as directed by the patient, including but not limited to schools, camps, recreation organizations, etc.

Thank you. We agree. The parent or guardian of the child is responsible for sending copies to any of the child’s caregivers; e.g., daycare, school, camp, etc. We have reworded the component to reflect this.

Asthma Care Manager (coordinate communications, education and care)

45. "care manager" sounds suspiciously like a managed care initiative for those who have been certified or for the medical home of the patient. Please clarify what this role is and who may perform it.

46. Care management could be done by home care.

47. The requirement of care management twice a year is not required for those with adequate control--this is over spending of funds.

48. Asthma Care Manager can be done in the home, and in some cases telephonic, but original (baseline) data should be done with a visit to the home to assess all conditions according to medical standards

49. Is universal use necessary? Adds cost, bureaucracy. EPR endorses patient-provider partnership and team approach, but only mentions 1 RCT that studied the care manager concept. (NAEPP-EPR-3 p.100)
50. The concept of a care manager being an essential part of the basket may be premature. The services being provided by a care manager should be in the basket but the methodology should not be prescribed in my viewpoint. For some providers there may be other methods that accomplish the responsibilities of the care manager and leeway should be given to the providers that have alternative methods to participate. The baskets should define the components of care necessary for an asthmatic, but not necessarily prescribe how it is accomplished.

Thank you for your comments. The title of ‘manager’ has been changed to ‘coordinator’. The intent is that, for consistently uncontrolled asthma patients co-management of the disease by a care coordinator would improve outcomes. The ‘who’ can be any asthma clinical team member such as physician, clinic or home nurse, asthma educator, etc. Again, this may only be necessary in the 15-20% of patients whose asthma is consistently poorly controlled.

Patient Skills

51. Inhaler technique should be checked at each visit and a minimum of twice a year. The issue of holding chambers is controversial and this seems to suggest all children should have them.

52. Nebulizers are seldom appropriate for children of school age and I thought this did not pertain to infants.

53. Education on medications should be done on an on-going basis since medications tend routine and done automatically

54. medication delivery device” wording vs. holding chamber?

We agree, it is intended that inhaler technique be assessed in the patient skills section of components; each child will be assessed as to the appropriateness of holding chamber and nebulizers.

It is expected education is ongoing and done whenever the patient’s care plan changes.

Environmental Factors and Co-morbid conditions

Environmental assessment

55. Environmental assessment should be done at least at every visit, especially if asthma not in control (not only for poorly controlled)

Thank you. When assessing asthma control, a discussion of triggers and allergens should always be part of the assessment.
56. Should specifically mention allergy testing (skin or in vitro) as method to identify allergens. (NAEPP-EPR-3)

Thank you. The referral to a specialist has been added to the component list.

57. Environmental Assessment: Consider adding environmental intervention products will be provided for those who qualify. (mattress and pillow encasements, air cleaner, Vacuum with Hepa filter)

58. I’m curious about families who have high deductible or are lower income and have environmental control challenges. Has coverage been considered for HEPA vacuums, air cleaners, mattress, pillow covers?

Thank you for your comments. Currently, these items are not included in the definition of DME. And, is not included in the components of this basket.

59. “When needed” is not a standard that consumers or providers can understand clearly. Who determines when an environmental assessment is needed – the patient, the provider, the payer?

Allowing for an unlimited amount of any service places greater risk on providers offering the basket. Unless the work group can recommend a more objective, concrete amount of environmental assessment services, those assessments should remain on a fee-for-service basis outside of the basket.

60. No description of what constitutes a sufficient environmental assessment.

Thank you for your comment. The ‘environmental’ assessment is the same as the ‘In-house’ assessment listed on the component list. The frequency is for those with consistently poorly controlled asthma and only if needed based upon the assessment of the provider.

Flu shots, pneumococcal

61. Could you provide the evidence for pneumococcal immunizations every 5 years in school aged children with asthma.

> 5 PNEUMO VACCINE ONCE

62. Pneumococcal vaccine every 5 years is a new requirement I have not seen elsewhere.

63. When did the PCV23 guidelines become mainstream for asthmatics? Is it for all asthmatics or only severe?

64. CDC ACIP now recommends all smokers and asthmatics 19-64 receive PPSV23 in addition to all adults ≥65. Of course conjugate vaccine is administered to kids, but I could not find any recommendation to re-administer any type of pneumo vaccine to
children (other than sickle cell, asplenia, HIV, immune compromised) (ACIP Provisional Recommendations for Use of Pneumococcal Vaccines – Oct 2008 and MMWR Oct 2000 a. Table 8 and 12)

65. Because the scope of the basket is limited to services provided within one year, services that are required every five years should not be within the standardized services within the basket. Instead, this vaccine should fall outside of the basket and remain a fee-for-service immunization.

Thank you for your comments. The pneumococcal vaccine should be administered to children only ONCE in childhood.

Identify / Treat co-morbid conditions

66. This is an unspecified and unlimited amount of services, thereby placing a greater amount of risk on providers. Co-morbidities could include mental health, obesity, allergies – an endless list of health issues that could place a provider with an extraordinary amount of services or expertise that can’t be offered within the price of a basket.

Thank you for your comment. The word ‘treat’ has been removed.

Medications (Medications are included in the basket)

67. I am unsure by the information provided in the Care components section (this may already have been considered), but wanted to comment that I would think that an MTM (Medication Therapy Management) pharmacist would be included as a provider to discuss the role of medications and to ensure proper technique, etc.

68. I also am unsure how the medications could be included in the basket of care… the number and expense of each medication used in asthma varies widely. Some may only be on a controller, other on multiple medications. How would this be averaged out for each patient?

69. I may not understand this correctly, but I am afraid that if the cost of the package was set, and the medication need was there, but the cost was nearing the “price set” for the package cost, a less effective therapy may be chosen to avoid the extra expense.

70. MDI holding chambers are currently not covered by most insurances.

71. Other than Nebulized Albuterol, there are no generic asthma medications, providing appropriate asthma care brings most pediatricians out of generic compliance standings required by insurance companies.

72. To include all of the prescriptions in the basket may not be feasible for the provider to figure out costs.
73. The recommendations in the Asthma basket of care states that medications are part of the basket of care. How is this basket going to be priced when the provider of the care for the basket is not a pharmacist? Will the “licensed medical professional” provide the medication along with the rest of the services?

74. “As needed” is not a standard that consumers or providers can understand clearly. Who determines when a medication or what type of medication is needed – the patient, the provider, the payer? Allowing for an unlimited amount of any service places greater risk on providers offering the basket. Unless the work group can recommend a more objective, concrete amount of medications, they should remain on a fee-for-service basis outside of the basket.

75. Remove from the basket, should be an expense outside the basket; may be appropriate to tie an incentive to medication compliance and control that would lower or eliminate a medication copay (Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc. 2003;43:173–84. 2. Bunting BA, Cranor CW. The Asheville Project: long-term clinical, humanistic, and economic outcomes of a community-based medication therapy management program for asthma. J Am Pharm Assoc. 2006;46:133–47)

76. Durable medical equipment - Remove from the basket, should be an expense outside the basket.

An enormous problem is that patients don’t fill prescriptions because of the cost. We are proposing that the cost of medications (and delivery devices) be included in the price of the basket. Providers and payers will be able to be innovative as they develop pricing and billing processes. Collaborating with pharmacists would be imperative. An additional phase of the baskets of care initiative includes the development of a work group to identify administrative and operational challenges associated with baskets of care. It is likely that these questions could be addressed with that effort.

**Topic Specific General Comments:**

77. Thank you for the effort that was put into this and for being open to comments.

    Thanks you for your work on this proposal, hopefully it will move forward!

78. Every other aspect of pediatric asthma care in this basket is already provided by pediatric practices and guidelines from the academy.

79. In commenting from the clinical side, we don’t seem to be breaking new ground here. I’m not sure what the vision is – is this a situation where coverage is not always there for
recommended services, or is the vision here to link payment with performance. From the clinical side, there is nothing controversial side regarding what’s recommended.

A general objective of the baskets of care concept is to encourage providers, payers, and consumers to think differently about health care services and where and how they are purchased and delivered. While the health care system currently pays for services on a per-service basis, baskets of care are intended to offer health care providers an incentive to be innovative in providing a given package of services in a way that supports effective, high quality, lower-cost care.

80. This is a very innovative basket of care and is perhaps the best example of how innovation in payment policy could improve care outcomes. The inclusion of drugs, devices and durable medical equipment, as well as a home assessment and care coordination, in this basket represents a bold step forward in improving care of chronic disease by making sure that patients will have access to all needed diagnostic, care coordination and treatment requirements for their asthma. In many respects, this basket should be a model for all chronic care baskets or bundles that might be developed in the future.

Thank you for your supportive comments.

81. I like the idea and the components. I don’t quite understand how it will be billed but I will stay tuned to further understand. We see about 40% of our population have some form of wheezing and we are working to be more consistent the components that was outlined. We do have a care coordinator, attempt to see our patients every 6 months and speak with them every 3 months, use PHS for our homecare and she is working closely with our care coordinator to assure better care. We have room for improvement but many of your components are already in place here.

Thank you for your supportive comments.

82. My concern is whether this basket will become an impediment to providing additional medically necessary services, e.g. spirometry on a yearly basis (or perhaps more) or allergy testing. Even if there is a provision for services outside of the basket, might this basket become a de facto standard and impede payment for these additional services, even when these services are conforming to NAEPP-EPR-3.

Baskets of care are meant to be uniform sets of health care services that can be packaged around a particular topic, procedure, or condition; they are not meant to include the full array of all possible services. However, baskets of care are not intended to limit the care received by a particular patient. In addition to the basket of care component services, other health care services can be delivered by the provider, but they may not be reimbursed under the agreed upon basket of care package price. Rather they could be billed and reimbursed via the current fee-for-service system.
83. Important to recognize the extra effort that is required to provide good/robust asthma care in this way and to “encourage” providers and health-care sites to provide evidenced-based care.

Main general concerns:
1) the care components are the same for all “asthmatics”, when NHLBI/NAEPP guidelines very much distinguish the frequency and level of care based on asthma severity and level of impairment/control. What is the definition of “asthmatic” who should receive this basket of care?

2) Some of the care components could be performed as non-visit care, and this is not reflected as an option in the basket.

3) There is an emphasis on office visits, without clear recommendations or prioritization as to what should really be happening at those visits (assessing symptom frequency per NHLBI/NAEPP should receive more emphasis, as should more frequent spirometry. Both of these are better supported than performing an ENT exam; however, the ENT exam will give you “credit” as a provider towards your basket criteria requirements).

84. There will be a real challenge though in that some of the basket recommendations require 2 or more actual office visits a year (ex: to check height and weight and do ENT/lung exam). The reality is that many times we do not see children this frequently in the office, and this would require more missed time from school (and parents from work), as well as more health care utilization and more time/effort trying to pull these children in for appointments.

85. Much of this care could really be done as non-visit care (ex: having a RN Care manager call for symptom updates by asking the symptom frequency in the first 4 rows of NHLBI/NAEPP Guidelines Summary, Figures 12 and 15). If there are concerns of incomplete control (per NHLBI/NAEPP guidelines) or concerns regarding level of asthma severity, then these are the children that should receive additional care.

Thank you. These comments have been addressed in previous responses. Also the component list has been revised and additional considerations have been added to the scope and component document.

86. What is the payment structure for the asthma basket of care?
This question came to mind when the providers that were speaking for the small outstate practices were commenting that they could "not afford" to include some of the tests/x-rays that may be needed to diagnose co-morbid conditions. Again my concern that this would put up a barrier for children to participate in the basket of asthma care unless they had mild, uncomplicated asthma. It seems to be counterproductive to have small practices compete with large health groups to participate as asthma basket providers. If this is the plan, I think some alternatives need to be considered to avoid ending up where we are now due to lack of participation by providers.
Consideration should be given to giving payments to groups of providers in a given geographic area to improve asthma in a population management strategy. Obviously, this would work better in outstate MN, so a different model could be considered in the TC metro area.

87. I think that the concepts and requirements are fairly standard and routine. The only concern I have is how much we are going to be reimbursed for all of this? Or is this amount yet to be determined?

_Baskets of care are intended to offer health care providers an incentive to be innovative in providing a given package of services in a way that supports effective, high quality, lower-cost care. Pricing structure will be determined by the provider and payors._

_The intent is that the baskets were developed such that both integrated systems and small, rural or non-integrated practices could implement the baskets they so choose. Since this is an exploration there are a lot of issues that will require further discussion as these baskets are being implemented. To the extent that payers elect to make the baskets of care available to beneficiaries, the law is explicit regarding requirements about payment, the law stipulates that there will be a single non-negotiable rate for each basket of care, but it does not require payers to contract for the baskets of care._

88. If this product were to be offered to the medical assistance/PMAP families, the contents of the basket should be re-evaluated and therefore the provider should have the opportunity to adjust the cost.

89. I have also heard that children on Medicaid or PMAP programs would not qualify to be included in the basket (implying that the basket parameters we have defined for good asthma care would not apply to them). Is this true?

90. In the future, if you are looking at a basket of care for MA and PMAP clients, please take time to get input and evaluate this basket. A MA and PMAP client basket of asthma care could be different.

91. Barriers: Please consider revising for families covered under PMAPs, MN Care, MA or those with high deductibles, they may need access to additional resources.

_The baskets of care provision of the 2008 health reform law does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers’ compensation, or no-fault automobile insurance._

92. With a complex chronic illness that has a wide scope of variability in severity and control, the idea of a comprehensive basket of care for children with asthma regardless of the complexity of their individual disease seems inappropriate. The high risk, moderate to severe patient with asthma that is poorly controlled and poorly managed require more specialized care and services. Pulmonologists and allergists, provide a different intensity
of care than primary care providers. A basket of care which includes this population together with those of mild to mild persistent severity, fails to encourage the appropriate level of care. Patients identified as moderate to persistent asthma should be managed by specialty care as the require frequent visits, close monitoring, an array of services to evaluate environment, identify barriers to care, and high levels of education and medications. Furthermore, the burden of care rests on the provider and doesn’t include incentives for the patients to comply with the care and management of their disease.

Thank you. We agree. The components have been revised.

93. I think that asthma “basket” follows the asthma guidelines very well. The emphasis on education has been well documented to improve asthma outcomes and has been poorly distributed to affected patients and families. The scope follows guidelines and is appropriate for the target group. Obviously, the very ill patient may fall out of these “baskets” but the minimums will cover the vast majority of these patients. It would be helpful to have some standardization for education but may be difficult to accomplish given the scope of the whole project. I fear someone will check a box to say it’s done if not held to a certain standard. If we reimburse for something, separately or together, we should get something in return (i.e. outcomes).

Thank you for your comments. The elements of good asthma education have been outlined. We are hopeful that the measurement group assigned to this basket will include a measure of the quality of education.

94. There are some potential concerns about the implementation of the basket. The exclusion of severe cardiac or respiratory illness is quite appropriate, but some more precise definitions will need to be developed and applied to these exclusions.

95. This basket appears to require a functioning delivery system that includes pharmacy and device delivery capability, something that will be beyond independent practices. However, if a mechanism could be developed to identify the accountable entity for receiving payment in a way that would accommodate independent practices without imposing excessive administrative requirements, this would also serve as a model for other chronic care baskets delivered from an office practice. From a practical perspective, this would also require creation of a mechanism that would make sure that patients with asthma cared for in a medical home do not receive additional coordination of care payments. The basket of care should also address the issue of lost medications (inhalers in the asthma basket), but the same question could also impact other baskets.

Thank you. These concerns are included in “Additional considerations” section of the final document. Also, payment and administrative/operational groups are expected to review this.

96. Will it be up to the clinics to set the “time allotment” for asthma visits or will the baskets-of-care committee make recommendations?
It will be up to the providers to determine time allotment for asthma visits. Innovation and creativity are encouraged.

97. The frequency contains a minimum but no other limits or standards. One provider could price the basket and provide the service once, whereas another provider could include multiple services. The consumer would have no way to compare the prices between the providers because the quantity of services is different.

Thank you for your comments. These are questions and concerns that have been raised for all of the baskets of care. Additional committees (measurement, administrative and operational) are being formed to address these concerns.