

Baskets of Care (BoC)
Operational and Administrative Challenges Phase I Work Group Report
August 18, 2009

Background

Task three of the baskets of care contract is to identify and propose solutions to operational and administrative challenges to implementing baskets of care. The original work plan was to convene **one** work group with administrative and operational expertise to identify challenges and recommend solutions. Through work with the seven basket subcommittees and review of public feedback it was clear that one area of challenge that would benefit from special focus was the claims and billing processing challenges. The Minnesota Department of Health (MDH) determined that it would be most effective to revise the work plan and split the work in to **two** distinct subcommittees. One Operational and Administrative Challenges Work Group (Phase 1) would focus specifically on eligibility, coding, claims, billing and payment in our current health care system, and a separate Operational and Administrative Challenges Work Group (Phase 2) will focus on broader operational and administrative challenges across all of the baskets of care.

Health plan and provider work group representatives, with expertise in billing, coding, claims processing, HIPAA, and other industry regulations and standards were convened for Phase 1. Their charge was to:

- Develop a plan that would allow the Baskets of Care to be paid for in the current health care system in a way that minimizes administrative burden
- Walk through 2 baskets, one of the baskets being for a chronic condition and the other being for an acute episode of care:
 - Chronic / Longer-term: Diabetes (Type II) or Asthma
 - Acute / Shorter-term: Total Knee Replacement or Low Back Pain
- Consider:
 - Eligibility / Insurance coverage and patient benefit plan (which is different from simple verification that the patient has insurance)
 - Payment
 - Claims / coding: determine if there is a way (within the confines of the mandated HIPAA transactions) to indicate that services were part of a basket.
 - How the information would be reported back on a remittance advice
 - Identify / create a methodology for package pricing of claims
 - Components that aren't currently reimbursed (i.e., care coordination)

- Assess whether to seek permission to use special codes and/or a waiver for HIPAA eligibility, claims/coding, remittance, prior authorization, referral standards

Phase I Work Group meetings were held at ICSI on June 24 and June 30, 2009 and were open to the public for observation. The input and recommendations for this subcommittee are outlined in this report.

Operational/Administrative Challenges Phase I Work Group Membership

A broadly representative group of individuals were recruited by the Minnesota Department of Health. Work Group members include:

- **Laurie Darst** Mayo Clinic
Administrative Uniformity Committee (AUC) Operations
- **Glen Eiden** Lead Engineering, Carol
- **Jim Eppel** Vice President of Network Management, Blue Cross and Blue Shield of Minnesota
Baskets of Care Steering Committee Member
Total Knee Replacement Basket of Care Subcommittee Co-Chair
Administrative Uniformity Committee (AUC) Strategic Steering Committee
- **Erika Greenlee** Children’s Hospitals and Clinics
Administrative Uniformity Committee Co-chair,
- **Ann Hale** Senior Director Provider Electronic Commerce and Operations, HealthPartners
Administrative Uniformity Committee (AUC) Chair,
- **Liz Herstein** Operations Quality Manager, Medica
- **Barb Hollerung** MN Medicaid, Minnesota Department of Human Services
Administrative Uniformity Committee Medical Code TAG Co-chair
- **Shelagh Kalland** Director Network Management Strategic Partnerships, Blue Cross and Blue Shield of Minnesota
Administrative Uniformity Committee Claims Data Definition Technical Advisory Group (TAG) Chair
- **Rahul Koranne** Medical Director, HealthEast Care Navigation Project & Bethesda Hospital, Health Care Home Payment Methodology, Steering Committee member, Co-chair of Health Care Home Workgroup “Patient Risk Stratification Models and Methods for Minnesota Health Care Program Rate Development
- **Patrice Kuppe** Director Administrative Simplification, Allina Hospitals and Clinics Administrative Uniformity Committee Past Chair
- **Cheryl Marton** Manager Provider Relations, Medica
- **Tina Morey** Director Provider Contracting, PreferredOne

- **Pam Pridgen** Allina Hospitals and Clinics, Contracts Manager
- **Sandy Rutherford** Chief Operating Officer, Kaleidoscope
Minnesota Medical Group Management Association
(MMGMA)
- **Katie Sayre** Senior Vice President of Health Plan Operations and
Government Programs, HealthPartners
Administrative Uniformity Committee Strategic Steering
Committee
- **Matthew Wiandt** Carol.com

Minnesota Department of Health Staff:

- **Katie Burns**
- **Sara Bonneville**
- **David Haugen**
- **Amy Luitjens**

Institute for Clinical Systems Improvement Facilitators:

- **Joann Foreman**
- **Cally Vinz**

Operational and Administrative Challenges Phase I Work Group Charge

Phase I subcommittee objective is to focus on billing, claims and coding challenges in the current payment system and to develop basket specific work plans for two basket topics.

Following a discussion of the four proposed baskets for a walk through (Asthma, Diabetes, Total Knee, Low Back), consensus was reached to focus on the *Total Knee Replacement* and the *Asthma Care for Children* baskets.

General Comments and Considerations

Attempting to create an innovative approach to payment for the Baskets of Care within the current health care services payment structure presented a significant challenge. Existing regulatory and accreditation requirements as well as existing benefit structures already in the marketplace for 2010 required the Work Group to recommend a two-phased approach to paying for Baskets of Care. For the first year (2010), Baskets of Care must be paid for within our current payment structure by modifying existing processes. Baskets of Care will likely need to be processed and paid for through a mostly manual process and will increase administrative burden and costs.

In subsequent years (2011 and beyond), there may be greater opportunities to pursue simplification of claims coding, billing, and payment processes and structures. This will potentially require exemptions to be sought to current requirements such as federal and

state reporting, accreditation, auditor and administrative standard exemptions. The goal would be to produce one bill using one code per basket.

However, from a payors perspective, the payment is challenging with the one bill approach because it doesn't always align the release of funds with the service delivery. This principle is important financially to self-insured employers and payors so they don't pay for services beyond their obligation. This may be a problem if there are changes in member liability e.g. member moves or is no longer employed as refunds or reprocessing would be involved which increases the administrative burden.

From a providers perspective it would be important for the payment stream to correlate in a timely manner following the delivery of services. Additionally from a patient centered focus this would allow patients to access health care dollars from their health care spending accounts in a timely fashion.

Although there may be opportunities to pursue simplification in years beyond 2010, there are still inherent challenges and complexities with Baskets (i.e. multi-entities, RX, determination of when a patient is in or out of the basket, patient moves, coverage terminates, switch carriers, change providers, new medical condition during basket – i.e. stroke). These types of complexities will still be considerable beyond 2010 for both the provider and payers who administer Baskets.

The work group was hopeful there would be opportunities to pursue simplification through influence of accreditation agencies, employers, federal and state regulators. This will need to be explored in the future.

The following are general considerations identified by the subcommittee:

- Health Care Home models continue to require consideration as part of BoC initiatives due to overlap that may exist between initiatives.
- Analogy of a “general contractor” to a basket owner seemed to aide in understanding basket concepts.
- Some benefit packages may not support baskets since many are already established for 2010 (some packages may never support this i.e. national plans, union plans, etc.). Comprehensive BoC benefit package consideration may be possible in 2011 benefit packages (negotiated in 2010).
- Some benefit designs may lend themselves to BoC more readily than others because of cost sharing, benefits structures, variables in co-pay or co-insurance between services (i.e. high deductible plans, etc.). These *could* be the focus for some baskets in 2010. However, high deductible plans have very specific IRS rules about what services (illness vs. preventive) are subject to deductibles.

- Some shifting of risk from payors to basket owner occurs because the basket owner is managing services and innovation within the basket. However, health plans and plan sponsors will still continue to be at overall risk if baskets are purchased through health plans.
- Patient engagement is a core component of most of the Baskets of Care. Patient engagement is a key component of accomplishing high levels of effective, efficient care. While increasing patient responsibility in their care may initially decrease interest in baskets of care, patient/provider compacts should be considered. The compact would be an agreement between the provider and the patient that delineates all care provided within the basket must be received from providers participating in the basket. It may be effective to use compacts to support patient engagement.
- While payor and providers will hold some responsibility for communicating information about care delivery and components of the baskets, patients will also be responsible for understanding what services are included and where those services should be rendered. To support efficient and high quality clinical outcomes patients will need to receive care from providers participating in that basket or they may be responsible for additional costs.
- Acknowledgement that a dual “system” of paying for health care will likely need to exist (current payment model as well as that for BoC). The reason being is not every provider or patient will participate in Baskets. Even if a patient selects a basket, they may have medical conditions (e.g. broken leg, stroke, strep throat where services are paid for outside of a Basket).
- In the current system we must maintain the capability for payors and providers to continue meeting the necessary accreditation, and other regulatory and purchaser requirements.
- Current methodologies for global payment used for prenatal care and for transplant care (although manual) may have some applicability to BoC payment.
- Life events must be considered for payment of the basket; some current examples of pro-rating payment exist. There will need to be a mechanism to “disassemble” a basket (i.e. unbundle care delivered in the basket and pay for the care using the current fee-for-service billing structure on a go-forward basis). Some examples include members changing employers, members moving, changing providers or experiencing an intervening medical condition (i.e. stroke)
- It will be necessary to understand and meet or recommend changes to the detail encounter reporting requirements of the Minnesota Department of Health. Instead of detail encounter reporting we need to focus on outcomes.

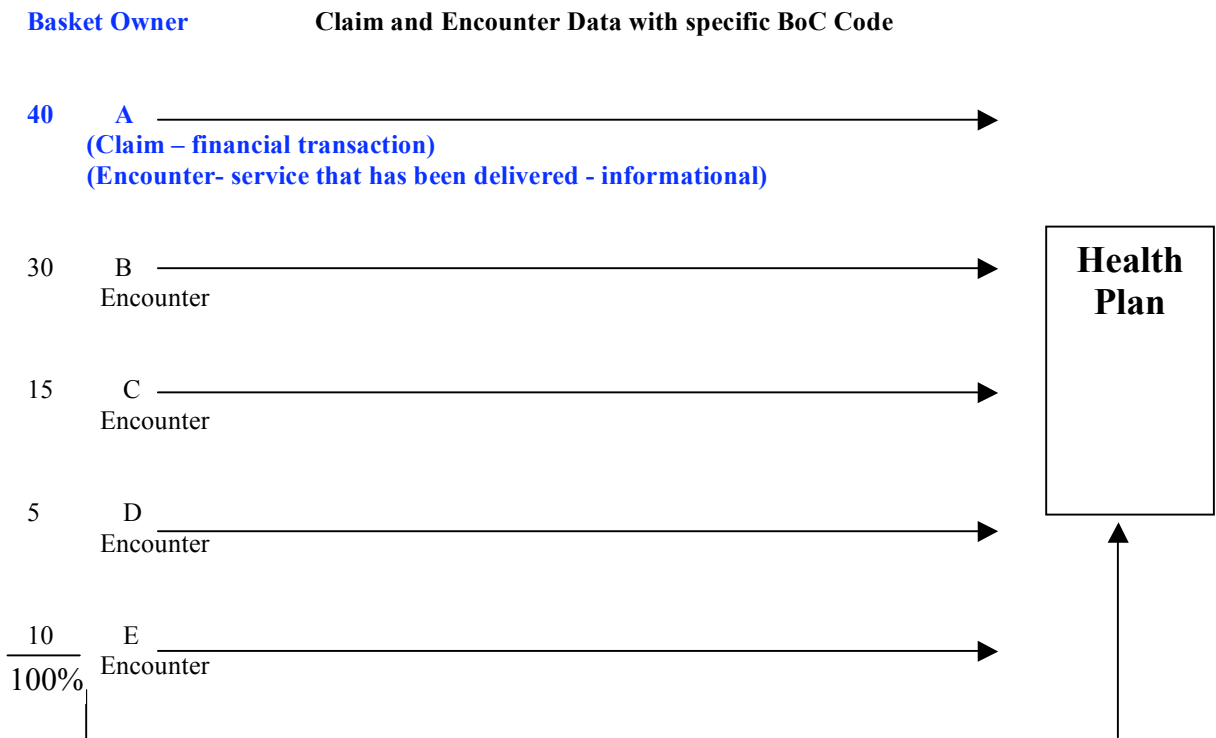
- Multiple accounting and business rules may exist in Minnesota regarding provider's subcontracting with each other (e.g., 1099 s would need to be issued).
- For patients with dual coverage there will be coordination of benefit issues if payment for BoC takes place outside the standard claim process. A patient needs an explanation of benefits detailing what the primary payor paid the charges in order for the secondary payor to process the remaining balance. It may be that the best candidates for BoC payment initially will be those with single coverage.
- Learning from national and local experience could be very beneficial.
- The inclusion of prescription drugs in the baskets present unique challenges given the separateness of most prescription drug benefits. Drug benefits are handled through pharmacy benefit managers (PBM's) and employer carve-outs.
- It may be wise to consider a withholding methodology based on quality matrix, which has been used by others implementing baskets or bundles of care. The subcommittee did not discuss this in detail.
- Using one bill makes it difficult to sort data and identify which approach is most effective
- Barriers for the smaller independent practices may be great and that these barriers may make participation in the baskets as owner or subcontractor burdensome

2010 BoC Proposed Encounter and Claims Data Flow

Following is a potential encounter and claims data flow process, it is for illustrative purposes. Please note, there is a contract between the health plan and basket owner. Contracts would also be established between basket owner and its partners in providing basket care.

The basket owner would submit the claim to the health plan while each subcontracted provider would submit encounter data.

EXAMPLE



The above model depicts data flow within current system. All encounters (A, B, C, D, and E) will account for 100% of patient care delivered and claims billed.

For example: A = 40% hospital
B = 30% surgeon
C = 15% physical therapy
D = 5% primary care provider
E = 10% home care

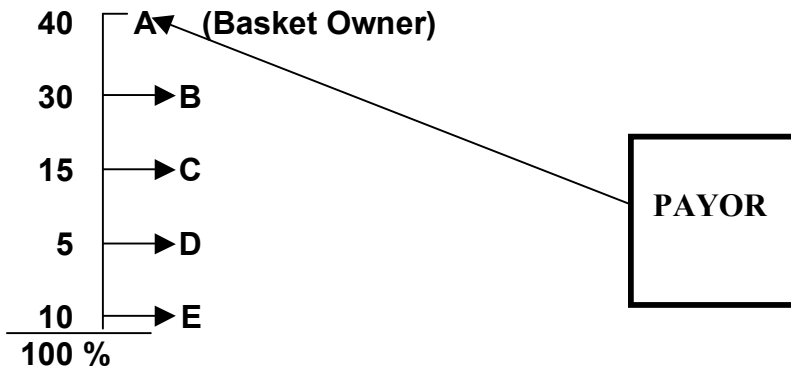
The basket owner (A) submitting a claim with other providers involved submitting encounter data only. The current system captures encounter data as informational; claims data is used for payment. The encounter would have an indicator identifying it was encounter data. The claim would also have an indicator that it was a basket. This model allows for the required detail to continue to be submitted for 2010. It would be envisioned that in the future this would not be required. This requires additional review giving consideration to whether or not the encounter should include billed charges or a zero or a penny (so that there is something in the field). This assumes basket owner uses appropriate I(institutional) or P(professional) claim type and if basket owner also delivers service, they would also generate a separate encounter.

2010 Payment Schedule – Installments

Below outlines a payment model:

Payment flows to the basket owner (A) who would then pay other service providers affiliated with the basket. Basket owner assumes member liability or could pass part of the member liability on to the subcontractors or member.

PAYMENT SCHEDULE - INSTALLMENTS



Work plan for Total Knee Replacement

- Provider develops and prices basket (may or may not include subcontractor relationships)
- Plan or basket owner will list pricing for each basket
- Member is instructed on their share of basket cost
- Patient eligibility for basket is verified (both clinically and benefit eligibility)
- Patient chooses the basket and provider and agrees to terms of the basket
- Notification to all providers and payors involved in the basket must be done (by the basket owner) and patient record flagged by providers and plan, identifying them as a basket patient
- Incremental claims for services delivered will be sent to health plan, and the basket owner will apply the proposed unlisted cpt code (TKR 27599, unlisted procedure, femur or knee) and generate an 837 for incremental payment request (for all services including those provided by subcontractors).
- Subcontractors submit required encounter data with the provider's standard charge on each line. This enables plans to determine cost of care attributed to each provider when multiple providers are part of a package. This is important for tiering and transparency for members.
- Providers would need to flag claim as an basket
- Providers would need to flag encounter with indicator it is encounter data
- Incremental payment remittance using 835 (may or may not require more than one “invoice” for this). Estimated cost distribution for a total knee replacement over a 90 day period (based on health plan claims data): 74% after knee surgery, 14% at 60 days and 12% at 90 days. A schedule such as this would mirror costs incurred.
- Use proposed payment model as outlined above (either basket owner pays subcontractors or plan pays subcontractors)
- EOB distribution per current mechanisms

Work plan for Asthma

- Provider develops and prices basket (may or may not include subcontractor relationships)
- Plan or basket owner will list pricing for each basket
- Member is instructed on their share of basket cost
- Patient eligibility for basket is verified (both clinically and benefit eligibility)
- Patient chooses the basket and provider and agrees to terms of the basket
- Notification to all providers and payors must be done (by the basket owner) and patient record flagged by providers and plan, identifying them as a basket patient
- Incremental claims for services delivered will be sent to health plan, and the basket owner will apply the unlisted cpt and submit an 837 for incremental payment request (for all services including those provided by subcontractors).
- Subcontractors submit required encounter data with the provider's standard charge on each line. This enable plans to determine cost of care attributed to each provider when multiple providers are part of a package. This is important for tiering and transparency for members

- Providers would need to flag claim as an basket
- Providers would need to flag encounter with indicator it is encounter data
- Basket payment would require monthly payments versus triggered by service delivery. There is current variation in payors' ability to accomplish this. Workable models exist for payors such as the "care coordination" payment currently being used.
- Payment remittance would be done using 835 (may or may not require more than one "invoice" for this)
- Use proposed payment model as outlined above (either basket owner pays subcontractors or plan pays subcontractors)
- EOB distribution in situations where payment is made on a monthly basis and patient does not receive services in that month could potentially be confusing to the patient. However this approach would be less onerous than the member paying all their liability up-front EOB distribution and member liability would need to be part of any education done regarding Baskets. Current Diamond model was referenced as a workable model.

Outstanding Items Yet to be Resolved for 2010

- To support the inclusion of drugs in the cost of a basket, it was recommended that a meeting be held with a representative from a PBM, a large retail pharmacy, and a representative from a pharmaceutical company to explore opportunities to manage the inclusion of drugs within some of the baskets. Issues related to existing benefit design for this could require approval from Department of Health or Commerce.
- In the professional and institutional claim formats there may be a potential place for reporting dates (Date: ASSUMED AND RELINQUISHED CARE DATES). This may not a good way of reporting care start date and care end dates in the 4010A1 version or in the soon to be 5010 version of the electronic claim records, although this has not been completely considered..
- Discussed at length how to indicate that services are related to a basket of care or otherwise packaged priced service such as transplants. We considered the potential need to pursue approval from X12 to use the K3 segment in the electronic claim transactions. Another option may be to use the Prior Authorization REF segment and initially require the prior authorization process to report the sale by a provider (and approval by a payer) of a basket to a particular member. Further discussion led to suggestion of using a condition code instead which would be requested from NUBC. We would request the special condition code to be used for the claims/encounters that are related to baskets of care/package priced services. In the case of a condition code, claims for the Baskets of Care would include: a generic condition code by basket + basket flag + specific cpt code + primary diagnosis code. Regardless of final solution, both institutional and professional claims would have to be addressed to accomodate

the differing structures that may exist for different sellers of a basket. It is the final recommendation of this workgroup that a final solution be developed by the AUC Claims DD TAG jointly with the AUC Medical Code TAG.

Principles and Elements of Future Basket Payment and Operational Models

The following elements and principles for future BoC payment model should include the following:

- Scalability of the process is critical. The processes must be able to handle the necessary volumes using electronic systems.
- Automation should be the aim, with one claim generated from the basket owner, this would move away from FFS billing. A payment structure must be established that does not require direct payor billing by small groups or independent providers when acting as subcontractors, this would be too burdensome and prevent these providers from participating in baskets.
- Benefit packages must support the components of the basket. Benefit design should be **all inclusive** for basket components; deductibles should apply to overall basket. No item in the basket would be excluded from payment. Coverage level would be determined based on the particular benefit design.
- Contracts should include specific language around recoupment, timeliness of reporting employee changes/terminations, and dictate terms of payment schedule (would be incremental and vary based on uniqueness of each basket)
- Basket owner takes responsibility and is at risk for any payment adjustments
- Specific codes should be assigned for each basket clearly defining what care is included in the basket
- Mechanisms for routine audit and quality data must be available to appropriate stakeholders
- A process for coordination of benefits must be clearly defined
- Pharmaceutical coverage must be resolved or deleted from baskets

Outstanding Items Yet to be Pursued for 2011

- Generate list of “special cause” items yet to be resolved that are not part of the routine path to follow for both data flow and payment flow
- Unique basket codes could be sought by MDH through AMA (takes approximately 6 months to acquire)

- Benefit redesign that considers the integration of baskets
- Exemptions sought at local and national level to accommodate aim of one code, one “invoice” per basket (i.e. accreditation, data reporting, etc)
- Need to work on modification of the eligibility transaction

Items possibly requiring consideration by Operational and Administrative Challenges Phase II Work Group and Baskets of Care Steering Committee

- Applications of cpt codes for each basket could be done differently by each “owner” thus creating confusion and lack of transparency for patient. Should a defined list of codes apply to each basket i.e. decide what services are in each basket with its corresponding code (CPT, Revenue, diagnosis, DRG)?
- Payers may apply coverage rules to the services within a basket. If baskets are meant to be treated as a single service, selectively applying coverage rules to services within the basket may cause confusion.
- In order for successful implementation of the BoC concept, this subcommittee recognizes the value of a multi-stakeholder collaborative where common implementation and value measurement could be shared.