Baskets of Care
Operational and Administrative Challenge & Work Group Phase Two
Issues by Category and Potential Solutions
September 17, 2009

It is the assumption of this work group in offering these potential solutions that the barriers can be overcome and trust that implementation will occur. A leap of faith will need to be taken for providers, employers, payers and patients.

The work group has identified operational and administrative challenges by category and has offered proposed solutions. Potential solutions are listed in italics. In some cases the work group has offered a variety of solutions, acknowledging that further exploration would be necessary before recommending a preferred solution.

1. Patient Engagement in Care

- Motivate patients engagement/compact
- It must be worth it to patients to be in a basket
- Consumer understanding may limit use of basket

Having the BoC administrative functions be initially transparent to the patient so the processes and system design can evolve. This will create less confusion on the patient's part. Have payment be structured in a manner that reduces the out of pocket responsibility of the consumer. This would support early adoption of the BoC concept, creating less barriers to the implementation.

Provide consumer education and engaging the patient as an active participant. Accomplish this via shared decision making so that they know the "rules of the road". Patient needs to be engaged to receive services at providers within the basket. The patient needs to be engaged both on a clinical level and a financial level.
Identify the "so what" for the patient when we don't have quality data so that patient will be interested and willing to participate in the basket. We need to have a "pilot" to create that data. Create an incentive for patients for using only the care they need. Provider and payer need to provide clarity that there are services outside of the basket and the patient will be responsible for the cost of those service or they go through fee-for-service payment.

2. Patient Volume

- Lack of volume of patients eligible (exclusions: medicare / medicaid, etc.)
- Employers will need to be requesting basket for it to be part of benefit package
- Consumers are not prepared to assess value, lack of evidence, data available and it is not presented in a manner that is understandable.

- Closed Networks

Open network so that any certified providers can participate in the program. (Constraints on innovation exist related to NCQA requirements).

Create a pilot setting in which the barriers, payment structures etc are overcome, so that it is possible to try this concept and implement, gather data and evaluate

Identify activated, informed consumers through employers to participate in the pilots. The lens in which patients initially view their health care is through their benefit package so the patient needs to be encouraged to use the baskets, this may need to be done through the employer.

3. Benefit Design

- Patient engagement
- Alignment of patient financial interest with benefit design
- Patient financial stake
- Pharmacy
- Can a patient "buy up" in the basket (ie: devices)

There are existing benefit designs that lend themselves to specific basket topics better than others. For example, preventive care may lend itself to a specific design and a procedural basket may lend itself to another type of benefit design.

A simple, straightforward (clean and easy to understand) benefit design will facilitate patient acceptance of this alternative care delivery / payment model.

Though the work group acknowledges the importance of including medications in some of the baskets, our current benefit design system makes it too complex to do this at this time. There are many barriers that need to be overcome, such as: generic vs brand, group purchasing, drug availability, PBM's, wide variation in benefit design.

Initially, the work group would recommend no "buy ups" and in the future, if a patient wants to "buy up" for a service or device, this would be managed and paid for outside the basket price. Initially it must be acceptable for the provider to determine that the patient who wants to "buy up" is not eligible for the basket.

4. Data Portability & Integration (PHR/EMR)

   - Clear communication of care delivered
   - Ensure that payment for a specific service is done once
   - Data portability should be electronic

Clinical, financial and administrative data needs to be portable. Electronic medical records supports data portability easier but it is possible to accomplish data portability outside the electronic environment. PHR's may also be a useful tool, which supports patient engagement and responsibility.

5. Measurable Outcomes

   - Some in-process measures will have to be used initially as a proxy for outcome measures
   - Consistent outcomes measures reporting
   - Measurement burden
   - Some measures difficult to acquire
   - Improved affordability
   - Improved patient satisfaction
   - Improved outcomes

Align currently collected measures with those required for baskets. We should not end up with an additional database with quality and patient experience measures, we should use the existing MNCM database.

Cost data must be defined and reported to a central location. Cost data should include comparison data of baskets vs fee-for-service. Cost data could include: total cost of care, cost to the payors and cost to the purchaser. Ensure that cost of care is not the only cost to be factored in the total cost of care ie: lost days of work.

There will need to be a control group so that cost comparison can be done.

6. Administrative Burden (manual processes, tracking, etc.,)

   - Getting billing, claims processing issues resolved
   - Identifying patient eligibility (insuring, clinical) are they in?
   - Regulatory requirements (credentialing, etc.,)
   - Implementabilty
   - May be prohibitive to small & medium size providers network (pricing, expertise, etc.)
   - Administrative issues with payment to subcontractors
   - Special cause exceptions: (multiple baskets, change in employment, moves, coordination of benefit)
   - Provider inability to comprehensively package baskets – (subcontracting)

- Need for ongoing baskets of care topic revision

This work group recommends a collaborative process so that those implementing baskets can network and learn from each other. This would support a pilot concept. In doing the pilot, data and learning should be shared. The collaborative process will allow modifications and need for change through one voice. Reproducibility will then be supported both by data and implementation models.

There is an Administrative collaborative vehicle through the AUC. We need a clinical delivery collaborative. There is assumed correlation between the two collaboratives.

As learning occurs, there may be regulatory requirement exemptions that are necessary. These exemptions should be sought as they become apparent. (Refer to the Phase I section of the operations report).

The work group identifies the need for a transition process for a patient to move from basket to a fee-for-service care deliver model. This process needs to be consistent among health plans implementing the baskets of care.

There needs to be a defined process and responsible party for the revision of baskets to reflect current evidence and health care environment changes. This is an ongoing activity to keep the baskets of care current with evidence.

7. Actuarial/Risk

- There will need to be coordination with fee-for-service care
- Need limits on cost/risk for each basket, this requires tracking
- Pricing basket to balance risk and price
- Complexity of implementation (pricing, risk, patient choice etc.,)
- Basket cost versus fee-for-service cost

It is difficult to separate the determination of risk and need for actuarial services from the administrative burden. There are resources that will be required to accomplish the mitigation of risk associated with implementation of baskets of care.

8. Consumer Opt In

- Effective marketing
- Managing patient expectations
- Not sure who we are marketing basket to
- Culture of concern over capitation versus case rate
- Lack of outcomes data makes it difficult to choose baskets

If baskets are to be successful, employers will need to support the use of a baskets. The marketing and uptake of baskets will be enhanced through employer engagement.

Incentives for patients to utilize baskets may be beneficial. If low risk patients opt out of the basket, it may create a unfavorable condition for those who would offer baskets of care.

Providers should be knowledgeable about the baskets but should always deliver the highest quality of care at the best price. The basket provides a structure for care that may be better for some patients and providers could recommend this to patients.

Also see response in #1 above.

9. Legal Issues

- Stark
- Antitrust
- IRS
- Gain sharing

This work group recommends a legal subcommittee to identify applicable laws and mechanisms to prevent legal issues from inhibiting innovation.

10. Miscellaneous

- Attempting to implement a few baskets may be more effective
- Coordination of health care redesign efforts (ie: HCH and BoC) needs to occur, identifying learnings that will enlighten us to whether they are compatible or mutually exclusive.
- Long term chronic disease management may be more difficult as a basket,

The current baskets encompass three care delivery categories:
Preventive care – preventive adults, preventive children, Pre-Diabetes
Chronic disease -- Asthma, Diabetes
Acute care – low back, total knee, OB - Prenatal

Some baskets appear easier to implement than others because of the overlap with HCH, administrative burdens and barriers. There are practical realities that led the workgroup to recommend that the baskets should be implemented in phased manner to allow for consistency and capitalizing on the learnings, choose the easiest basket for initial roll-out and then progress to something more complex. The work group suspects that the acute care baskets may be the most feasible for early implementation.

There was also consideration that the market should dictate how many and which baskets are implemented based on the demand and value to the purchaser. This does not preclude any payer / provider / employer organization from choosing to collaborate to offer many different baskets at one time.

Providers need the ability to exclude patients in a HCH from basket of care participation. The work group felt that an individual patient could not participate in both a HCH and a basket of care because of administrative complexities.

11. Provider Engagement

Physician compensation must be considered.

Risk to providers must be mitigated in the initial rollout so that there is willingness for providers, plans and employers to want to participate.