

# **Health Care Home Payment Workgroup-- Consumer/Patient Payment Considerations**

## **Recommendations October 30, 2009**

**Background:** The Consumer/Patient Payment Considerations for Care Coordination Payments workgroup was convened in August 2009 by the Minnesota Departments of Human Services and Health with the charge of making recommendations to the Payment Methodology Steering committee by October 30, 2009 on the following deliverables:

### **Deliverables:**

- Make recommendations on care coordination payments affects on patient/member financial liability for the entire market.
- Identify strategies that respond to consumer concerns about information collected by providers and shared with payers to assign a payment rate.
- Recommend communication strategies/tools for consumers/patients to make informed choices about participation in and choosing a health care home

The Workgroup met four times between the beginning of September and the end of October 2009. The workgroup was led by co-chairs John Tschida, Courage Center and Katie Sayre, HealthPartners with support from Carolyn Allshouse MDH.

### **The workgroup members included:**

Ken Joslyn	Medica
Deb Kersten	Allina
Janet Jorgenson-Rathke	ICSI
Jennifer Geisen	MN Disability Law Center
John Tschida	Courage Center/HCH Consumer/Family Council
John Wheeler	HCH Consumer/Family Council
Katie Sayre	HealthPartners
Mary Kurvers	HCMC
Patrick Herson	Blue Cross Blue Shield of MN
Philip Stoyke	Woodbury Family Practice
Sheri Alme	Target Corporation
Wendy Berghorst	Park Nicollet
Mike Flicker	Lakeview Clinic, Sauk Centre

**Deliverable 1:**

Make recommendations on care coordination payment effects on patient/member liability for the entire market.

**Recommendations:**

1. No member liability (cost sharing) applied to health care home services
  - a) Very important to reduce barriers to access/care and to avoid consumer confusion
  - b) Note – DHS has determined that there will be no member cost sharing for State Public Programs.
  - c) Commercial benefit products have certain complexities which can be addressed by aligning the benefit structure with compatible reimbursement approaches.
2. Flexible reimbursement approaches such as global payments should be structured so that health care home is part of the clinical infrastructure. This approach would address some of the complexities associated with certain commercial benefit designs, including HSA products. This approach would mitigate member cost sharing and opt-in issues. This would allow health care home to seamlessly be applied to patients as appropriate in the clinical setting, similar to the application of electronic medical records.
3. For commercial business, it is desirable to have a consistent consumer experience and application of benefits within an employer group for patients seeing the same provider and/or covered by the same payer.

**Deliverable 2:**

Identify strategies that respond to consumer concerns about information collected by providers and shared with payers to assign a payment rate.

**Recommendations:**

1. The stratification work group is proposing an assessment tool to determine patient complexity and stratification. If this tool is completed at the clinic site, summary data, not including detailed clinical PHI, should be used to communicate complexity of patient needs to support the payment processes. Data elements such as CPT/HCPCS codes, diagnosis code, and/or modifiers would be used to support payment processes.
2. The detailed assessment tool, containing sensitive clinical and socioeconomic information, should not be submitted routinely to the payer for billing purposes. Submission of the detailed assessment is not necessary to support either fee-for-service or global payment approaches.
3. Provider-payer contracts allow for chart audits as appropriate to substantiate the service level and intensity which was billed. This is similar to Evaluation and Management (E&M) code submission, which does not require submission of the detailed medical record information.

4. The Administrative Uniformity Committee (AUC) should define coding that would be used consistently by providers to submit their claims.

**Deliverable 3:**

Recommend communication strategies/tools for consumers/patients to make informed choices about participation in and choosing a health care home.

**Recommendations:**

1. From a consumer perspective, it is preferable to have health care home “baked in” to the patient experience because:
  - a. Many patients will not understand what is different with the introduction of health care homes.
  - b. If the health care home is baked in, i.e. the way the clinic delivers care, then the patient essentially opts-in or opts-out by choosing clinics that are certified as health care homes.
  - c. The health care system is itself complex and difficult to understand.
2. Based on recommendations from The Health Care Home Consumer/Family Council, four levels of information should be provided to patients and families:
  - a. Basic information about what a health care home is, which clinics/practitioners are certified as health care homes, and the value of health care home services to the provider and patient.
  - b. Information about choosing a health care home, including specific clinic health care home competencies and services.
  - c. Information about being an informed, activated patient and how to partner with providers. This includes mutual expectations such as making the health care home provider aware of all other health care services to facilitate care coordination.
  - d. Providers are encouraged to use various tools to engage patients to achieve outcomes, including partnership agreements, orientation packets, or compacts. This should communicate what it means for a patient and the provider team to be active partners in managing the patient’s condition.
  - e. How to be an advocate beyond the patient’s own situation and become involved in the clinic's quality improvement activities.
3. Key features of health care home that should be highlighted include: 24x7 coverage; coordination of services between providers, care venues, and across the continuum of care; shared decision making; care plans as appropriate to achieve health outcomes; and patient relationship with practitioners and the health care team.
4. MDH and/or DHS should promote newly certified health care home to create community-wide attention and a unified message. A special logo to designate certified health care homes may be useful to highlight these providers in the community.
5. Health care home materials should be developed in additional languages, preferably in audio, video, and other visual formats. It is recommended that DHS

or MDH develop these multi-lingual materials and make them available to the community.

### **Workgroup Discussion and Considerations:**

1. The consumer considerations workgroup had significant discussion about each of the 3 deliverables they were charged to address. Some of the main themes discussed were a desire to support the relationship between the patient and primary doctor, avoid barriers to participation for the patient and provider and provide helpful information for both the patient and provider.
2. For commercial business, member cost sharing is a complex issue due to the varied benefit plan designs (i.e. deductibles, coinsurance, copays, and other benefit accumulators), products (i.e. self-insured plans, union-negotiated benefits, Medicare, etc.), and regulatory implications (e.g. IRS rules for High Deductible Health Plans/Health Savings Accounts)
3. It was noted that if there were costs to patients for care coordination some patients would choose not to participate in the health care home (as has been observed in the Diamond project). There is a wide body of research supporting these phenomena. Additionally, if providers have to determine a patient's insurance eligibility for care coordination payment in order to provide needed care coordination services, it would be a barrier to the spirit of health care home and the primary providers desire to provide quality care. There was significant discussion that implementation of health care home should be part of the way providers practice and viewed seamlessly to the patient needing those services. In addition, while implementing a health care home should be transformational in a clinic and practice, the goal should also be to try to make it easy for the provider to receive payment for care coordination.
4. Providers understand the need to protect their patient's personal health information. If risk stratification requires additional information to be collected about the patient that is not typically collected to determine the patient's level of risk severity for payment, providers prefer that they not be required to submit the details of that information to insurers (unless required to do so in the context of an audit). The ability for the provider to assure privacy to their patient helps to preserve the trusting relationship between patients and providers. In addition, insurers indicated they don't want unnecessary information.
5. There was significant discussion around the concept of helping patients understand the value of health care home to them. There was discussion that there should be many ways to assist patients in understanding health care home and at many levels, provider to patient, clinic to patient and state to patient.

## **Appendix**

### **Health Care Home background that informed our discussion**

The design principles for health care home in Minnesota focus broadly on the continuum of “health” and incorporate expectations for engagement of the patient, family and community. Fundamentally, health care home is a change in the patient-provider relationship augmented by financial structures and measurement of results. Expectations for transformative change must be sufficient to achieve these results. These expectations include:

- **Patient- and family-centered care** will be foundational to the Minnesota Health Care Home program. Patients/families/consumers will be involved in all aspects of program development.
- **Clinical health care teams** where patients and families work in partnership with the clinical team to plan and coordinate their care. Clinical team members work as a team and members work at the “top of their license” in order to provide a coordinated efficient approach to care delivery.
- **Quality improvement teams** will be required at the practice level. A health care home will have an active practice-based quality improvement team that includes patients/families as equal team members.
- Participation in a **learning collaborative** to support and foster practice-level change is required.
- **Financial structures** must be aligned to promote this transformation and must include adequate risk adjustment for medical and non-medical complexity.
- **Recertification** is based on outcomes. Minnesota will be moving to an outcomes-based system in its recertification of health care homes. In the certification and recertification process, a balance will be sought between fidelity to the model (criteria) and flexibility for innovation. A goal of the program is to maximize clinic flexibility to achieve all of the outcomes.

### **In early 2009 workgroups with members from all stakeholder groups developed five health care home standards. These standards are:**

1. Processes are in place to ensure access and effective communication between the patient/family, members of the care team, and other providers.
2. Health care home providers create and use a registry that is searchable for tracking and managing the health of their patient panel.
3. The health care home demonstrates a system of care coordination that strives to achieve seamless, patient-centered care.
4. Care plans are created for patients with a predetermined amount of complexity or chronic illness.

5. The health care home measures its performance and engages in a collaborative quality improvement process in order to further the triple aim of patient's health, patient and family experience and improved value.

### **Payment Methodology Project Principles**

1. Care coordination payment is conditional on certification as a health care home per statute and rule.
2. Care coordination payment will reflect the patient's medical complexity, and will evolve toward reflecting non-medical complexity such as limited English-language skills, cultural differences, and other barriers to health care.
3. Providers will prospectively self-identify and enroll patients eligible for care coordination payments, using a common method across payers that include information on medical and non-medical complexity.
4. Care coordination services will be coded consistently across practices and payers, fostering uniformity in definitions of the duration of service, level of patient complexity, etc.