# PAP Recommendation Discussion Points
## May 20, 2008

DHS leadership reaction to the three recommendations was varied, with a) very positive reception for increasing primary care service payments, b) positive reception for the proposed primary care coordination fee if clarification and assurances are provided, and c) negative reception for the proposed increase in admin. Accountability and availability of data (including paid claims data or something functionally equivalent) were mentioned. Discussion points for refining each of the three recommendations are presented below.

Increasing RBRVS conversion factor for primary care service codes

- This recommendation, if implemented, would call for new contractual language between DHS and OHP contractors
- DHS leadership requested a description of data that would be submitted – and in what format – so that DMAP can monitor and evaluate the impact of increased primary care payments on patterns of care and health outcomes
- DHS staff suggested that each contractor submit a plan for its own monitoring and evaluation of the impact of increased primary care payments
- DHS leadership also asked what sorts of assurances can be provided that the increased payments for primary care services will not be "hijacked" to fund other care, but will flow from DHS through contracting plans to primary care practitioners at the levels embodied in the per capita costs and capitation payments.

Needed: specification of codes involved, mechanisms for getting increased payments to practitioners providing primary care, and description of how DHS will be assured that contracting health plans internally evaluate this change and provide DHS with the data and information it will need to monitor performance and hold contracting health plans accountable.

Establishing a primary care coordination fee

- This recommendation would also require new contractual language
- DHS leadership requested clarification on what outcomes (specifically, what improvements in health outcomes) would be expected as a result of this recommendation

- DHS leadership also requested a more detailed description of who would receive the fee, what the fee would pay for that isn't already a part of the management of care under OHP contracts
- Assurances of accountability would be required, including data submittal and performance monitoring and evaluation at the contractor and primary care practitioner level.
- DHS staff suggested that each contractor submit a plan for its own monitoring and evaluation of the impact of increased primary care payments
- DHS leadership raised the possibility of withholding a portion of the fee against performance as measured by specific outcomes improvement.

Needed: A clearer description of the intended health outcomes improvements, who will receive the fee and what they will do to earn it, how accountability will be built into the process, what elements will be included in each contractor's plan for administering and evaluating the PCC fee, and the feasibility of financial incentives to perform.

Increased administrative component of premium

- DHS leadership were reluctant to accept a recommendation to increase admin during a department-wide push to reduce admin as a part of increased efficiency.
- Significant variation of admin as a percentage of total costs was cited as an indication that economies of scale are working against smaller plans.
- Transparency and accountability were emphasized as requirements both for any increase in admin and for justification of current admin levels.
- Direct linkage between admin costs and improved health outcomes was cited as a general criterion for approving admin costs at current or increased levels.

Needed: A more detailed description of additional administrative responsibilities to be funded with the increase in admin, and how these responsibilities link with improved health outcomes for OHP enrollees. Also, a description of how accountability for administration in general can be built into new contract language to assure accountability for performance.