PAP Meeting Notes: October 16, 2007
DRAFT

Trending

Judy Mohr Peterson summarized the trending component of rate setting as currently practiced. She referred the PAP to the description of physician cost trending in the PwC report on Per Capita Costs, noting that the utilization trends are based on OHP encounter data for a 4 to 5 year period. She also noted that PwC uses external trend factors provided by CMS, including Medicare trend factors. Judy also noted that in the absence of paid claims data, PwC needs Medicare and commercial cost data, and also needs to factor in the Medicaid experience of other states.

Questions and comments on trending included the following:

- Where in the range of trend factor values does PwC select the value to be used in developing per capita costs, and what criteria are used in selecting this value?
- How does PwC go beyond Medicare and other CMS information to supplement OHP encounter data in developing trend factors?
- Budget-balancing measures shouldn't supplant policy factors in determining trend factors – how is this safeguarded against currently?
- Estimating costs of care should be kept independent of budget and legislative decisions.
- PwC has appeared in the past to ignore the fact that in some cases, billed charges are less than the cost of care.
- The PwC process is very mathematical, and we need to find a way to go beyond strict mathematics to smooth out rate changes resulting from annual ups and downs.
- How are new technologies accounted for in the trend?
- The medical CPI could be used as another benchmark that could be used in addition to (or instead of) Medicare based trends.
- What sort of feedback loop does PwC use to identify areas where its trend prediction assumptions were mistaken and to make corrections to those assumptions?

The question regarding how new technologies are accounted for in the trend was answered during the meeting: Ed Deery of the ASU pointed out that the PwC trending includes a factor for the effects of past new technologies, although it doesn't predict what new technologies will emerge.

Judy closed her presentation by asking for additional suggestions or comments from PAP members through PAP staff.

SB 329

Barney Speight summarized work underway and planned on SB 329, the general health reform "blueprint" passed by the 2007 legislature.

Barney noted that some sort of medical home/primary care reform will likely be a part of the SB 329 design, probably including:

- Aggressive primary care for the chronically ill
- Changes in the reimbursement stream to support more aggressive primary care for the chronically ill
- Increased accountability for primary care

He also noted overlap between the work of the PAP and the SB 329 efforts, particularly in the areas of delivery system and financing.

Comments included the following:

- An effective medical home/primary care reform effort will not simply provide the current "12-minute visit" to more patients. It will increase the scope of what is provided in the typical primary care visit.
- What measures will be taken to increase quality of care, and who will have this responsibility?
- Given the prospect of Healthy Kids, open enrollment in OHP Standard, and broad health reform under SB 329, the factors used in developing per capita costs and capitation amounts will need to be reviewed and adjusted.

Barney concluded by suggesting that we do all we can to assure open communications between the PAP and the SB 329 committees, and that we work together to support improved access, more efficient delivery of

services, and higher quality care within the OHP and in broader health reform.

Physician Costs

Bob DiPrete summarized current factors affecting physician cost calculation in Oregon, and noted some efforts underway in other states to revise how physician costs and payments are calculated. These efforts were summarized in a handout, and included:

- Redefining Health Care: Creating Value-based Competition on Results –advocates reorganizing medical care around specific conditions and reporting risk-adjusted outcomes for those conditions as a means of orienting the system away from competition on price and toward competition on value to patients. Asserts that if value were judged by outcomes per dollar spent, efficiency and innovation would improve and costs would decline as they have in other industries. This model assumes that reimbursement will be structured around episode-of-care payments.
- Prometheus Payment Model – involves taking a clinical practice guideline for a particular condition, estimating the cost of delivering the care in the guideline, and then turning that into an "evidence-based case rate" to cover all of the care by all of the providers who will be involved with the patient's care.
- Comprehensive Payment for Comprehensive Care – Physician Payment - proposes moving away from a "dysfunctional payment system" and adopting a "fundamentally new model of payment for primary care, replacing encounter-based reimbursement with comprehensive payment for comprehensive care. This would include "new investment in adult primary care, with substantial increases in payment over current levels… Income to primary physicians is increased commensurate with the high level of responsibility expected." The developers of this approach claim that "Our model establishes a new social contract with the primary care community, substantially increasing payments n return for achieving important societal health system goals, including

improved accessibility, quality, safety, and efficiency." Basically, this approach would estimate the costs of primary physician care based not on current practice or recent experience, but on reformed practice.

- Market-based - views physician costs as a function of what the market will bear (based on the assumption that there is a health care market in the first place, which many observers feel is an open question). In this view, one could calculate the cost of physician services by specialty using a formula something like this (oversimplifies) example:
    - Take the total annual cost of a FTE physician in a given specialty in an efficiently run system (physician compensation and overhead and other business costs associated with the physician practice), and divide by the total number of patient visits to an FTE physician in a year. The result of this calculation is the cost of one unit of service.

Bob then identified some criteria that might be used to evaluate alternative approaches and to develop recommendations for how we might change our approach to determining physician costs as part of rates development for the OHP.

Comments on physician costs included:

- We need to move away from the CMS methods of using resource based relative value scales (RBRVS) and develop alternatives more suited to Oregon
- We need to define more clearly what we mean by a medical home/reformed primary care and what that implies for what we will expect from physicians.
- We to identify the financial (and other) incentives we want in place for physicians (and other providers) to move us toward our policy objectives.
- We need to identify the performance indicators that should be used to measure our progress with physician payments toward our policy objectives.
- We need to identify barriers to access, especially relating to capacity, and to identify how we can improve capacity to meet patient needs.

- Capacity increases alone are not enough – we need to improve the effectiveness of the primary care visit. The medical home model will only be effective if primary care is delivered in a different manner than is currently the case.
- Primary care physician supply is insufficient to meet our needs. We need to increase the rate of primary care physician graduates from med school. We also need to improve the incentives for physicians to remain in primary care rather than converting to a specialty.
- The current system for identifying physician costs is too procedure-based. It needs to be changed to place greater emphasis on cognitive care, especially if we intend to reform primary care.
- Pay-for-performance is a promising concept, but we need to explore if further and make certain it can help us meet our policy objectives.

Bob concluded by saying that he will work with PAP members and DMAP staff to develop examples of alternative policy approaches to identifying physician costs for discussion at the November meeting.