PAP Recommendations, Revised and Reformatted

Purpose of the Policy Advisory Panel

The Policy Advisory Panel (PAP) will identify policy issues associated with the rate setting process and frame recommendations on those issues so that they can be explicitly addressed.

The PAP has developed a set of policy guidelines which will be amended over time and which include the following:

1. Per capita payment amounts should be sufficient to cover the cost of care in the aggregate for OHP enrollees. Contracting health plans should pay providers at levels sufficient to cover the cost of services.

2. Value-based purchasing should guide decisions about capitation rates and provider payments.

3. Primary care has a high priority in terms of both health outcomes and cost-efficiency, and assuring adequate primary capacity and access is the shared responsibility of DHS and OHP contracting health plans.

4. Managed care helps to assure sufficient capacity and access and the alignment of incentives to promote efficient and high quality care. Managed care enrollment should be increased wherever possible.

Recommendations

These recommendations include some which can and should be addressed during the current cycle of per capita cost development and capitation rate development, and some which should be addressed later.

Recommendation 1: Clinician payments should reflect the OHP services required during the upcoming rate period as indicated by OHP policy changes, rather than the services provided in the past, trended forward.

Note: Although the term "clinician" is used broadly in Recommendations 1 and 3, elsewhere it is used coextensively with the term "professional

services", as defined in per capita cost development.

Success measures:

The rate setting process is transparent and based on documents that clearly outline policy changes (e.g., benefits, eligibility, delivery system), as well as the associated costs.

ASTAP work:

Collaborate with ASU to create the methodology and documents outlining policies and costs.

Recommendation 2(a) and 2(b): Clinician payments (amount and structure) should fully represent the value of primary care in meeting the policy objectives of the OHP. To accomplish this, it will be necessary to increase payments for primary care, and perhaps necessary to develop a new structure for primary care payments. Possibilities include but are not limited to: **a) an increase in the RBRVS conversion factor for primary care services, and b) a primary care case management fee**.

Note: Behavioral health and dental issues will be addressed in future recommendations.

Success measures for Recommendation 2(a):

Increased:

a. Access to preventive care.
b. Early diagnosis and treatment.
c. Outpatient management of chronic conditions.
d. Post-discharge patient compliance with effective treatment plans.

Success measures for Recommendation 2(b):

e. Rates support contracting health plan exploration of more effective approaches to primary care, including but not limited to options from HB 3626 (2008 Session).
f. Plans develop and submit to DHS proposals on primary care

improvement approach design, implementation, and evaluation
f. Primary care case management models defined and successfully implemented.

ASTAP work:

Evaluate the potential impact and pros/cons of the following:

a. Washington's increases in RBRVS conversion factors for certain evaluation and management codes.
b. Geographic adjustment to the RBRVS.
c. Minnesota's and Alabama's inclusion of services under targeted case management.
d. Inclusion of the 2008 care coordination codes.
e. Payment of a care coordination fee, modeled after the PCCM payment, to support the implementation of more effective approaches to primary care

Recommendation 3: Where possible, OHP clinician payments should create incentives that support OHP policy objectives. These incentives may be different for physical health, behavioral health, and dental health.

Success measures:

a. Increased access to preventive care.
b. Increased early diagnosis and treatment.
c. Increased outpatient management of chronic conditions.
d. Increased post-discharge patient compliance with effective treatment plans.
e. Medical home models as defined.
f. Reductions in avoidable hospital admissions and readmissions.
g. Timely and culturally competent provision of needed care in an appropriate setting.
h. Implementation of evidence-based practices in state-funded behavioral health services as required by SB 267 (2003 Regular Session)

ASTAP work:

Collaborate with ASU to research efforts in PEBB, Medicare, Medicaid and

other insurance programs (including pay-for-performance) to align financial incentives in support of policy objectives.

Recommendation 4: When increasing payments for primary care services, DHS should take care not to reduce payments for other services unless those reductions are independently justified. Physician payments should not be viewed as a zero-sum budget item.

Success measures:

a. Payments for primary care services would show an increase adequate to support sufficient primary care capacity and access.
b. Payments for other services would be adequate to support sufficient capacity (specialty care, hospital care, behavioral health care, etc.).

ASTAP work:

Collaborate with ASU to:

a. Evaluate the pros/cons of using a market basket index to calculate increases in payments for primary care services.
b. Evaluate the pros/cons of using a market basket index to calculate increases in payments for other services.
c. Identify and evaluate other options for indexing increases in payments for primary care and other services.

Recommendation 5*:* DHS should develop an explicit method for comparing trend (in its broadest sense) and risk adjustments against an experience-based benchmark.

Success measures:

Accuracy of trend rate assumptions used in the capitation rate development can be determined empirically after the fact.

ASTAP work:

a. Collaborate with ASU to determine the best way to gauge the

accuracy of trending after the fact, including validation of assumptions used in trending.

b. Consider using more recent data, including draft versus final cost reports.

c. Assure continued transparency in the application of changes occurring after the trend data period.

Recommendation 6: DHS and OHP contracting health plans should consider the advisability of collecting and using payment and cost information (e.g., paid claims data).

Success measures:

The issue of using payment and cost information from contracting health plans in calculating per capita costs and capitation rates is evaluated for positive and negative impacts.

ASTAP work:

a. Collaborate with ASU and OHP contracting plans on the evaluation of the pros/cons of using paid claims data, including administrative, actuarial, and legal aspects.

b. Consider alternative kinds of information on payment and cost experience.

c. Include in this evaluation a review of practices in other states.

Recommendation 7: DHS should explore the feasibility of a stabilization mechanism that would smooth variances in capitation rates resulting from rebasing per capita costs and from changes in trend factors.

Success measures:

a. Alternatives are clearly outlined and intentionally selected.

b. Greater predictability in capitation rates from one contract year to the next.

ASTAP work:

Collaborate with ASU to consider alternative methods for smoothing

variances over time and evaluate these alternatives for policy decision-making.

Recommendation 8: DHS should explore the feasibility of including in the capitation rates an explicit component to support the development and implementation of improved approaches to primary care to meet OHP contract requirements and to assure good outcomes for OHP enrollees. This capacity may pertain to risk management, infrastructure for program changes, emerging technologies, or other factors necessary to the effective management of care under the OHP.

Success measures:

a. OHP contracting health plans are better positioned to respond to managed care issues.
b. New capitation rate component is sustainable.

ASTAP work:

Collaborate with ASU to:

a. Investigate practice in other states.
b. Identify CMS guidance on structuring the new rate component.
c. Identify alternatives, with pros and cons, for development of an explicit capitation rate component either in admin or in the overall rate.

Recommendation 9: DHS should develop safeguards to assure that trend factors are not shaped by budget constraints.

Success measures:

a. Safeguards are in place to assure trend factors are not shaped by budget constraints.
b. Medicare budget neutrality factors, such as employed in physician reimbursement, are excluded from OHP rate setting.
c. Any Oregon Budget constraints are explicitly identified.

ASTAP work:

Collaborate with ASU to recommend safeguards to prevent budget constraints from entering into the trend assumptions.

Recommendation 10: In developing capitation rates, DHS should account for the fact that the use of experience-based data can cause downward pressure on contracting plan payments to providers. A case in point is the cycle in MHOs wherein reduced capitation amounts have resulted in reduced provider wages, and reduced wages have in turn resulted in reduced per capita costs, and so on.

Success measures:

There is a safeguard to prevent the cycle of lower capitation payments causing reduced provider payments, which in turn produce lower per capita costs.

ASTAP work:

Collaborate with ASU to analyze the impact of reduced provider payments on cost-to-charge ratios as used in developing capitation rates, and recommend a safeguard to prevent continual erosion of provider payment.