Physician Cost PAP Discussion Document

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This document includes four sections:

1. Background and context
2. Current approach to calculating the cost of physician services
3. Alternative approaches
4. Considerations in weighing strengths and weaknesses of these alternatives, and
5. Next steps toward a policy recommendation

Background and Context

The costs of physician services have been recognized as a critical piece of developing per capita costs and capitation amounts since the beginning of the OHP. Since access to primary care has been emphasized from the beginning in the priorities underlying the OHP benefit package, the importance attached to paying adequately for physician care is greater than would be justified simply in terms of the cost of physician services as a portion of the costs of all covered care.

The policy guidelines for the work of the PAP include assuring access to primary and preventive care, paying enough to cover the cost of care, and making certain that the state acts as a prudent purchaser of health services and coverage. There are indications that physician payment levels calculated as part of the OHP per capita costs may not result in capitation amounts that are sufficient to support adequate payment to all physicians. These indications include difficulties encountered by contracting health plans in recruiting and retaining primary care physicians with adequate practice capacity set aside for OHP patients. As a result, current OHP

enrollment is straining the ability of contracting health plans to assure that primary care appointments are available timely and in an appropriate setting.

Current difficulties will only be made worse if OHP enrollment is further increased through the implementation of Healthy Kids (which would make the recruitment and retention of pediatricians even more critical), a re-opening of OHP Standard (which would require more capacity in physician specialties that typically manage chronic diseases in adults), or the implementation of broader health reform (as called for in SB 329) that included significant Medicaid expansion. This means that policy recommendations regarding how we define and determine the cost of physician services should reflect current access issues and also access requirements anticipated with proposed OHP expansions.

Perceived problems with physician payments are not unique to Medicaid, or to Oregon. This discussion paper includes a summary of proposed alternative approaches to determining the cost of physician services as a step in setting physician payment levels from around the nation. Much of the discussion of alternatives includes analysis of whether the use of the Resource Based Relative Value Scale (RBRVS) method developed in the 1980s has adequately accounted for the value of cognitive vs. procedural medicine. Many primary care physicians (and those concerned about their compensation and practice capacity) feel that the RBRVS method has resulted in relatively high compensation for some specialties whose practices are mostly procedural (involving the laying on of hands and instruments) at the cost of physicians hose practices are mostly cognitive (discussing medical history, health concerns, alternative treatment plans, and overall health maintenance strategies).

One concern, then, is that the RBRVS method undervalues cognitive medicine when assigning "relative units" to physician care, which are then multiplied by the "conversion factor" to yield a cost for a given service. In theory, the relative units would reflect the resources (including time and materials) required to provide a given service, but in practice many primary care providers have been left feeling that their time is undervalued.

There is an additional concern with the way the RBRVS methodology has been applied. CMS has used the RBRVS as a budget control by reducing the conversion factor as required to compensate for increases is physician payments under Medicare. Since OHP physician costs calculations are based in part on the RBRVS conversion factor, this acts to reduce physician payments in the OHP.

The policy context for considering alternative methods for defining and measuring the costs of physician care includes how these costs are going to be translated into payments. So, it seems appropriate to bear in mind a few issues relating to physician payment systems and the incentives they create. In his paper *"Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform"* (The Commonwealth Fund, September 24, 20007) Harold D. Miller notes some of these complicating factors:

- Payers often do not have an incentive to invest in preventive care, since the payoff in terms of better health and lower costs occurs in the (distant) future and may accrue to other payers.

- Under most payment systems, providers are paid more for patients experiencing adverse events, particularly serious adverse events resulting in multiple complications, and the providers' "profits" on patients experiencing such events may actually be higher than on patients with no adverse events.

- Current payment systems generally do not pay hospitals or physicians more to manage the needs of patients with complicated conditions after discharge from the hospital or to work proactively to encourage and assist the patient in complying with post-discharge instructions in order to improve outcomes and prevent rehospitalization.

Miller goes on to identify several weaknesses of current pay-for-performance systems, including that most "P4P" systems focus on rewarding processes rather than outcomes and that because of the fragmentation of care, it is often difficult or impossible to clearly assign responsibility for performance to a particular provider.

In addition, Miller lists potential goals for effective value-based health care payment systems, including the following:

- Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high quality, efficient, and patient-centered manner.
- Payment systems should support and encourage providers to invest, innovate, and take other actions that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
- Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside their control.
- Payment systems should encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.
- Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with the costs of care for both payers.

Finally, Miller identifies issues and options for improved health care payment systems, including at least two that qualify as policy issues:

- How the actual level of payment should be determined.
- Should payment changes be required to be "budget neutral"?

Current OHP Approach to Calculating the Costs of Physician Services in Managed Care

Costs of physician services are currently calculated based on encounter data submitted by contracting health plans. This encounter data is intended to reflect accurately the services provided to OHP enrollees as covered by the OHP benefits determined by funding level and the prioritized list. Based on the utilization levels

indicated by the submitted encounter date, the OHP actuary (PricewaterhouseCoopers, or PwC) than applies cost of service factors derived from Medicare payment levels for professional services.

> *We used the Medicare fee schedule as a benchmark for the cost for physician and certain other services, consistent with the rate setting methods developed in prior biennia. We used the relationship between 2006 Medicare allowable amounts and billed charges for specific services to develop cost-to-charge ratios for each professional services category. (Oregon Health Plan Demonstration; Analysis of Calendar Years 2008/2009 Average Costs; September 22, 2006; PricewaterhouseCoopers; Section III, pp.20 & 21*

Alternative Approaches

As previously mentioned, there are efforts underway to develop alternative methods for defining and measuring the costs of physician care, and/or for translating these into payment systems. It is worth noting that discussions about costs of physician services tend to overlap with discussions about physician payments, and vice versa. Also, a good part of these discussions nationally involve envisioning new approaches to defining the role of the primary care physician and the medical outcomes expected, and these considerations mean that alternative approaches to determining physician costs are forward-looking not simply in terms of trending, but also in terms of envisioned changes in physician practice as opposed to historical and current physician practice.

Attached to this discussion paper is a summary of some of these alternatives, and the most relevant to Oregon's policy objectives and circumstances are discussed below.

- 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.

Considerations in Weighing Strengths and Weaknesses in Alternatives

The policy guidelines developed (and being developed) for the PAP are one appropriate basis for identifying strengths and weaknesses of policy options. These guidelines imply criteria such as:

- Will this option help to assure that payments cover the cost of care? Does this option support the policy objectives for future delivery systems and provider practice, and not simply the status quo?
- Will this option help to assure adequate access to primary and preventive care? To what extent? Enough to meet the needs of planned health reform and OHP expansions?
- Is this option consistent with value-based purchasing? Does it make the best use of available resources to achieve improved health for Oregonians?
- Does this option reinforce managed care? Will it help to expand managed care capacity and enrollment? Will it help improve the effectiveness of managed care in achieving outcomes consistent with the PAP policy guidelines?
- Will this option help to align incentives – financial and other – for patients, providers, and other stakeholders so that policy guidelines are met?

Considerations not linked with the PAP policy guidelines may also prove useful, and as these are identified it may be advisable to revise the policy guidelines accordingly.

Next Steps Towards a Policy Recommendation on Physician Costs

It is important to remember that the Policy Advisory Panel should make policy (and not technical) recommendations. Given the time available and the work to be done, PAP discussions and the resulting recommendations should focus on what ought to be done rather than how it might be done. PAP recommendations will go to DHS, and it will be the responsibility of DHS to investigate the best methods for acting on the PAP recommendations that are accepted.

Once the discussion of alternatives and how to evaluate them has reached a point (hopefully at the November meeting) where the most promising policy option(s) can be identified, staff will develop draft recommendations to be finalized through email and telephone communications as soon after the November PAP meeting as possible.

Presumably, the PAP recommendation will reflect in policy terms a delivery system and roles for physicians that are consistent with a vision for the OHP in 2010 and beyond, rather than 2007 and prior.