DRAFT Physician Payment Recommendations

Here are draft recommendations on physician payments. It has been pointed out that they are still somewhat redundant, so please review them with concision in mind as well as what needs to be added or otherwise changed. It would also be helpful if we can work toward putting these recommendations in some sort of priority order, perhaps grouping them into high, medium, and "might be nice" levels of importance. Also bear in mind that these will remain draft until the PAP has had the chance to work through other issues (trend, hospital, admin, etc.) and that the recommendations as a set will be finalized in February or March. If you can get me your comments sometime in the next week, I'll work on getting these recommendations in better shape so that discussion at the December meeting can be efficient and we can move on to trend and perhaps hospital costs.

Thanks.

Bob

General Recommendation

In general, DHS should develop OHP physician payments using value-based purchasing methodologies consistent with OHP policy objectives, including an emphasis on health outcomes as a critical measure of health care quality and effectiveness.

Specific Recommendations

1. Physician payments should be developed to reflect the services we want from physicians during the upcoming rate period, rather than the services provided in the past. For example:
    a. A medical home model might mean increased practice responsibilities for primary care physicians, indicating the need for increased payments
    b. Access to needed care in the most appropriate setting, including alternatives to face-to-face physician/patient visits, may imply changes in physician payments

Physician payments should reflect the role of physicians in OHP delivery systems as they are being enhanced, including changes envisioned through the SB 329 planning process and the Physician Access Improvement Plans.

1. Physician payments should be based on cost factors that better represent the value of primary care in meeting the policy objectives of the OHP, including
   a. Adequate access to primary care
   b. Early diagnosis
   c. Outpatient management of chronic conditions
   d. Post-hospital discharge patient compliance with effective treatment plans.

   This may require a reevaluation of the relative weights given cognitive and procedural physician services in determining physician payments.

2. Physician payments should be developed so as to maximize accountability for cost, effectiveness, and quality of care.

   Transparency is an important element in the development of physician (and other health care) costs and payments. DHS should develop and use rate-setting methodologies that are explicit and clearly explained.

3. DHS should develop approaches to using the RBRVS methodology that do not include measures taken by CMS to keep within its own budget constraints.

4. Where possible, OHP physician payments should create incentives that support OHP policy objectives.

5. OHP physician payments should encourage patient choices that improve health outcomes and reduce the costs of effective care (e.g., through increased payment for cognitive physician services that enable patients to develop healthier behaviors).

6. DHS should consider determining physician costs and restructuring physician payment around episode-of-care payments

as a means of valuing care in terms of outcomes per dollar spent versus resources expended per service.

7. When increasing payments to physicians in certain specialties based on increased costs, DHS should take care not to reduce payments in other specialties unless those reductions are independently justified. (Physician payments should not be viewed as a zero-sum budget item.)

8. Physician costs and payments (as a whole and by specialty) should be viewed as a part of overall health care costs and payments, and all health care costs and payments should be developed using methodologies consistent with OHP policy objectives. This includes payments to all outpatient care team members, as well as physicians.

The PAP also suggests that the ASTAP consider recommending that DHS review the work of other states in reforming physician payments, including:

a. Minnesota's per member per month payments to medical home providers for managing services to patients requiring more than $12,000 in health care services per year;
b. Washington's increase to its RBRVS conversion factor to supplement resources for certain "evaluation and management codes";
c. Minnesota's and Alabama's listing of services that ought to be included in case management.