

MEMO

To: Oregon Health Policy Board

Cc: Tricia Tillman, Health Equity Policy Review Committee
Priscilla Lewis and Craig Hostetler, Safety Net Advisory Committee Co-Chairs
Carole Romm and Jim Russell, Medicaid Advisory Committee Co-Chairs

From: Denise Honzel and John Worcester, Health Incentives and Outcomes Committee
Co-Chairs
Bart McMullen, Payment Reform Subcommittee Chair
Glenn Rodriguez, Quality & Efficiency Co-Chairs

Date: November 16, 2010

Eric Parsons, Lillian Shirley, and Members of the Board:

The co-chairs of the Incentives and Outcomes Committee and the chairs of our Quality and Efficiency and Payment Reform subcommittees have reviewed a document entitled “Health Equity Policy Review Committee: Major themes” marked “draft” and the minutes of the Health Equity Policy Review Committee’s discussion with the staff of our committee. We’ve also reviewed the Committee Specific Recommendations of the Safety Net Advisory Committee and an e-mail reflecting two issues raised by the Medicaid Advisory Committee. We appreciate the close review all of these groups have given to our draft committee report. Unfortunately, the timing has not permitted us to discuss this with the committee as a whole. Therefore, we have revised our draft report to address issues the review process has surfaced where we are confident in the committee’s thinking but have refrained from revising the report to address ideas that have not been vetted by the committee.

This letter summarizes how the four of us propose the Board integrate these three sets of ideas into the ongoing work of our committee and the OHA staff. We are committed to collaboration with each of these groups during the implementation phase of this work.

Recommendations of the HEPRC: Expand quality standards to include standards for cultural competency such as Culturally and Linguistically Appropriate Health Services Standards (CLAS) and create payment incentives to ensure that providers meet these standards. Work with racially and ethnically diverse community organizations to generate standards.

Plan to address: Cultural competency is the sort of structure or process standard that might be a metric for measuring attainment of a level of performance of a primary care

home and/or a basis for an incentive payment. We note that the Patient-Centered Primary Care Home Standards, which we have endorsed, include the capacity to communicate with patients in their preferred language and the subcommittee document on patient-centeredness, which is attached as an appendix to the report, includes measures of respect for patient language, values, and culture. Cultural competency should be addressed as metrics are adopted for implementation of the PCPCH standards, a standard patient experience survey is developed, and pay for performance programs are designed. The HEPRC has also recommended using payment incentives to encourage patient-provider cultural matching. It seems to us that this concept deserves further discussion; perhaps our committee staff should kick off that discussion by working with HEPRC staff to examine any evidence that matching adds value over and above the value that would be attained from a provider's attainment of appropriate cultural competencies.

Recommendation of the HEPRC: The HEPRC has suggested use of a “health burden coefficient” and the SNAC has recommended finding a way to risk adjust for social disparities so that these factors—not just medical risk—are taken into account in establishing payment levels.

Plan to address: Committee staff has flagged the need to consider this issue as risk adjustment systems are developed and included it in a revised timeline for OHA work. This will, of course, require a search of the literature to determine how to measure this burden.

Recommendation of HEPRC: The HEPRC has also suggested adopting a reimbursement policy for community health workers; and the SNAC suggested reimbursing the work of panel managers, behaviorists, pharmacy managers and others engaged in care improvement activities.

Plan to address: We agree that this work needs to be supported by a reformed payment system. The question is how best to do it. The Incentives & Outcomes Committee prefers to move away from fee-for-service models of payment toward payment methodologies that assign responsibility for providing services while allowing providers flexibility in how to do it. In that spirit, we would recommend that primary care base payment and episode payment systems clarify responsibility for these functions and provider contracts set payment levels adequate to support this work, whether it is done by employees of a practice or community health workers, behaviorists or others that may cooperate with the practice.

Recommendation of HEPRC: THE HEPRC has recommended working with diverse community-based organizations to ensure that needs of patients from diverse backgrounds are met in the patient-centered care model.

Plan to address: The staff timeline for OHA work has been revised to flag this issue.

Recommendation of HEPRC: Require providers to collect cultural data at the most granular level; conduct satisfaction surveys by race and ethnicity, and include questions about perceptions of bias in the surveys. Contract a third party to collect data in order to ensure neutrality, inclusivity and transparency in the process of data collection and analysis. Engage racially and ethnically diverse communities in the development of data-sharing agreements, including the collection, analysis and dissemination of data. Use data to assure accountability for health equity outcomes.... [U]se race/ethnicity-conscious metrics and language to demonstrate the high priority given to equity.

Plan to address: The committee has discussed the need to collect data in a way that permits examination of the results of quality data by subpopulation group; this should include results of patient satisfaction surveys. We support building this into the work of developing a standard tool for measuring patient experience, other quality and efficiency metrics, reporting systems, payment systems, and the state scorecard.

We agree that the data collection and analysis must be done in a credible way. The committee report has flagged the importance of rigorous and transparent evaluation of payment reform pilots and of provider performance. Exactly what structure for data collection and dissemination would be most satisfactory is a project that deserves careful attention. This work has been identified as 2011 project in the staff timeline.

Recommendation of HEPRC: Collaborate with organizations that serve undocumented populations and other uninsured people to better understand their health beliefs, health literacy, experience with health care and the health disparities they are facing.

Plan to address: This collaboration is important in the delivery system transformation phase of the work. We suggest that organizational representatives be invited in the learning collaboratives the staff timeline envisions convening in 2011.

Recommendation of HEPRC: The HEPRC recommended two specific textual changes—one to the Incentives and Outcomes Committee’s board presentation and the other to the draft committee report. (1) The presentation identified eliminating complications and waste as the goal of new payment methodologies. The HEPRC said eliminating inequities should be added as a goal. (2) The draft committee report said “Stop consuming an ever greater share of public and private resources on health care expenditures.” The HEPRC recommended adding “with the exception of addressing health disparities.”

Plan to address: We are confident that there is broad agreement with the assertion that eliminating inequities should be an important work of the state’s delivery system transformation efforts, but we do not believe the committee would agree that addressing inequities should require an increase in total resources directed to health care services. The thrust of our report was that there should be a reallocation of

spending in order to achieve our health improvement goals. We know this will be difficult because no group of providers will be eager to experience a reduction in revenue in order to free up resources to fund more urgent activities. We have changed the language of the committee's sixth recommendation to recognize the possibility that resources will need to be redirected to addressing health disparities both to improve health outcomes for some subpopulations and to save money in the long run. As implementation decisions are made for payment methods and payment amounts, we will undoubtedly need to revisit these issues very concretely.

SNAC Recommendation: The statewide scorecard on the health of Oregon should include mental health, dental health and vision indicators.

Plan to address: We agree, but the scorecard is not being developed by the committee.

SNAC Recommendation:

- Create accountability without creating administrative burden. Consider the differing capacities of entities to collect and report data, especially safety net providers. Encourage safety net entities to collaborate and standardize data, Take into account current capacity to report and provide technical assistance and other supports to ensure accurate and manageable data collection.
- In adding requirements for PCPCH infrastructure and reporting, consider removing or augmenting current requirements so that safety net providers don't become overburdened (i.e. cannot simply add additional reporting requirements and add resources on top of current mandates).

Plan to address: The draft report noted the need to balance value and burden of reporting; we suggest safety net providers be consulted for their views as metrics and reporting systems are developed. The committee report's recommendation on the primary care delivery system has been changed to specifically recommend that OHA and other payers invest in helping providers develop measurement and reporting capacity.

SNAC Recommendations:

- There needs to be flexibility as to how this transition is implemented, especially for safety net providers that serve vulnerable populations.
- Review of the Federal Qualified Health Center and Rural Health Clinic prospective payment system (PPS) needs to occur in order to support full transition to a patient-centered primary care home model. In a transition period, current payments systems such as enhanced reimbursement should be maintained until support for comprehensive, quality services (including enabling services such as care management, interpretation, transportation, etc) for vulnerable populations is built into all payment systems.

Plan to address: This issue has been flagged for consideration in the implementation timeline.

SNAC Recommendation: Transition payments are needed to incentivize successful implementation of elements of the primary care home (PCPCH) model.

Such payments may include:

- Same-day visits - (the ability for patients to see both a primary care physician and behaviorist on the same day and for the clinic to bill for this “same-day visit”).
- Coordination with emergency or urgent care, hospitals and specialists. Assure an effective feedback loop, which should incentivize both the primary care providers and those in other parts of the system.
- Supporting efforts to implement electronic health records (EHR) in clinics and achieve meaningful use. Utilize EHR data as a tool for stratifying patients to inform payment for mental health, substance abuse, co-morbidities and social conditions.
- Reimbursement for defined work and providers that improve care, such as panel managers, behaviorists, pharmacy managers, etc.

Plan to address: The purpose of the primary care base payment system that the committee recommends be adopted recognizes that much work that needs to be done in primary care homes is not adequately paid by the fee-for-service system. We are not inclined to support adding new fee for service codes or creating special fee-for-service rules when our efforts need to be addressed to paying differently.

As to the coordination issue, we have suggested episode payment strategies and service agreement tools be adopted to further this objective. The committee has suggested that some payers may wish to pilot providing payment incentives or base payments to specialty providers to encourage them to take on new roles.

SNAC Recommendation: In the transition path for primary care, the payment reform committee envisions some payment in the form of shared savings. Shared savings revenue to practices could diminish over time because, as efficiencies are achieved in the delivery system, the level of reimbursement could be reduced. The reduction in reimbursement may in turn jeopardize safety net provider ability to maintain newly-formed infrastructure needed to sustain a primary care home approach.

Plan to address: This issue is not unique to primary care. During committee discussions, it was clear that all providers are anxious that “shared savings will disappear.” In fact, they must disappear if the recommended total cost objectives are to be met. The implementation challenge will be to balance the need to reduce waste and to keep costs for employers, government, and individuals at or below the rate of inflation with the need to set payment levels that adequately support the delivery system. The answer, we believe, is for payments to cover the costs of efficient care. The challenge is

particularly great in view of the multi-payer nature of our health care system. The need to address this issue is clearly called out in our report.

SNAC Recommendation: Payment reform should include payment for comprehensive primary care services, including mental, behavioral and dental health in addition to alternative care services, some of which include those provided by naturopaths, acupuncturists, oriental medicine providers and chiropractors. The MAC also recommended that the committee recommend integration of behavioral and oral health integration with primary care.

Plan to address: The PCPCH standards, which the committee has recommended the Board adopt, clearly call for primary care homes to offer mental and behavioral health services. The use of a base payment system and episode or even global payments in lieu of fee-for-service code-based system should provide flexibility for primary care homes to provide alternative care if they conclude that will produce better outcomes for their patients.

The standards require primary care homes to offer appropriate preventive services and specified routine services, but there is no specific reference in the standards to oral health. Qualified plans under the ACA must provide certain children's dental preventive services without charge. As the metrics for the PCPCH standards are developed in 2011, the role of oral health in the primary care home should be addressed.

SNAC Recommendation: The payment model needs to be changed for all patients and not just chronic disease patients to support fundamental change at the practice level.

Plan to address: This is consistent with the committee's second recommendation.

SNAC Recommendation: Purchasers should work with insurers to organize payment reforms to shift the burden of navigating the multi-payer system away from the providers. Carriers should be responsible for making payment transparent and easier to navigate for providers and patients.

Plan to address: The committee's recommendations to standardize payment methodologies and to identify performance metrics for use in reporting and incentive payment are all headed this direction. During the implementation phase, OHA should monitor the success of alignment efforts.

SNAC Recommendation: If payers/providers can opt out of serving the safety net population and contracting with community providers, due to the complexity of care, some will. This burdens the few providers that will see Medicaid/Medicare patients. OHA contracting standards could incentivize participating providers to have a balanced patient load that reflects the needs of the community—by demographic characteristics or type of coverage.

Plan to address: The need for broad provider participation in serving Medicaid and Medicare patients is certainly great given that they will make up a growing share of Oregon's population. The committee has not discussed this concept; it deserves further exploration by OHA.

We hope that as time goes on, the health equities review process will be increasingly well-integrated into our work.