



November 5, 2010

Eric Parsons, Chair
Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

Dear Chairman Parsons and Members of the Oregon Health Policy Board:

The OMA appreciates the work of the Health Incentives and Outcomes Committee and the sizable task that was before them. Health system reform has been hotly debated among our membership, and our members have shared their own unique perspectives and insights on all sides of this issue. The OMA is pleased to offer the following comments on the Health Incentives and Outcome Committee report dated October 12, 2010.

While we appreciate the work that is represented in the recommendations, the report does appear to be short on details. While it makes strong points about primary care and primary care funding, it is not at all specific about how to change the payment system to create the environment where positive change in the primary care delivery system can occur. The OMA looks forward to participating in the further development of the proposals needed to transform the health care delivery system. Our comments related to the six proposals are included below.

Recommendation #1: Standardize payment methods (but not rates) to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services.

Relevant OMA Principles:

- Oregon should implement one standard payment system.
- The payment system should increase simplicity and decrease complexity.
- Only follow Medicare where it makes sense.
- The new payment system should be transparent, and should be created in a transparent process.
- Out-of-state insurers and self-insured entities need to comply with Oregon's standard.

The OMA supports the notion of trying to implement one standard payment method for Oregon's payers. While we understand why the Resource Based Relative Value Scale (RBRVS) was selected as the base payment system from which to build, the Medicare systems methodology often falls short in several areas. There is currently not consistent use of the RBRVS components – different payers choose whether or not to use fully or partially implemented

relative values, some use the geographic practice cost indices; others may implement use of the budget neutrality adjuster. Not every payer uses the same year's RBRVS. Additionally, the system does not work for some specialties such as pediatrics.

Oregon's system should not be constrained by Medicare, but should use it as a starting point to create a payment methodology system that works for Oregon and is simple to use for providers. In creating Oregon's system, we should be aware that changes in the current system could create unintended consequences, and our system should not be slow or unwilling to address those problems.

Oregon should also be bold in finding ways to require the same payment standards be applied to national payers, self-insured and other out-of-state insurers. If self-insured and out-of-state insurers are not held to the same standards, the goal of standardizing the system will be lost. If they cannot comply with the same payment methodologies, they should not be allowed to compete in the Oregon marketplace.

Recommendation #2: Move forward decisively to transform the primary care delivery system.

Relevant OMA Principles:

- A robust primary care system is essential in Oregon.
- The primary care system needs to be well-funded and sustainable.
- A traditional gatekeeper model is not what physicians or patients want.
- The Patient Centered Primary Care Home (PCPCH) should not be the sole purview of the primary care physicians (PCPs); primary care for chronic and other conditions could fall under either PCP or specialist purview depending on the situation.

The OMA believes that to achieve the goals of improving outcomes and reducing costs in PCPCHs, existing rules will need to be changed. For example, the current payment system inadequately compensates care that is not face-to-face. Physicians will need to be allowed to manage their patients by phone, e-mail or even Internet video calls and be paid for that management.

Administrative procedures should be created that allow both open and closed referral systems, and should be evaluated on effective care, patient experience and cost. In both systems, clear guidelines regarding the referral process should be established.

The OMA also wants to ensure that the certification and the documentation necessary to comply with the PCPCH do not burden the primary care system with administrative reports or with other barriers to providing efficient and effective care.

Patients will also need to take responsibility for their lifestyle choices. Patients need to be financially incentivized to become committed partners in maintaining a healthy life and meeting desired outcomes.

The PCPCH should allow whichever physician that can take care of a condition effectively for the lowest cost, be they a specialist or a PCP, to care for that patient. If specialists are performing primary care, they should be paid the same amount as a PCP provided they meet applicable PCPCH standards.

Recommendation #3: Focus measurement and payment efforts in areas of significant cost impact or significant defects in the quality of care, where the potential for improvement is greatest.

Relevant OMA Principles:

- Physicians potentially affected by any change should be involved in selecting common focus areas and that process should be transparent.
- Peer reviewed scientific evidence should be used to select common focus areas.
- Existing appropriate use criteria, guidelines, clinical data and registries that are developed by specialty societies and consensus bodies such as the US Preventative Services Task Force should be encouraged and adapted when available in a collaborative process with specialists and PCPs.
- Reducing cost should not trump providing clinically effective care.
- Reducing administrative costs and the burden of complying with administrative rules and regulations everywhere in the system, including patients, physicians, hospitals, purchasers and payers, should be a priority.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.

The OMA understands that this recommendation is intended to move towards cost effective and efficient case rates for common focus areas. However, specialists should participate in creating benchmarks and should also be included in a system that uses pay for performance to incent desired outcomes. We should be careful that we do not move from a fee-for-service system that sometimes incents more expensive care to a managed care system that sometimes prevents physicians from providing sufficient care.

Recommendation #4: Patient and family engagement are critical. Encourage the delivery system to become more patient-and family-centered.

Relevant OMA Principles:

- Patient and family-centered engagement is important in a reformed health care system.
- Patients need meaningful health care choices and they should have a stake in how health care dollars are spent.
- Patients need to be stakeholders in appropriate utilization of healthcare resources.
- Through benefit design, patients should be held accountable for the use of preference care versus necessary care.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.
- A system that limits patient access to high quality care is unacceptable and may not decrease costs.

- POLST forms and Advance Directives should be encouraged to make sure that everyone's end of life wishes will be known and respected.

The OMA is concerned about how patient and family engagement will be linked to payment reform. While involving patients is important, sometimes the patients will not agree with the accepted science and benchmarks. For example, many families and patients do not receive the appropriate immunizations. How will physicians be held accountable for outcomes when the patient portion of the decision network has different goals and a different knowledge base?

Recommendation 5: Initiate use of new payment incentives and methodologies. Including pay-for-service performance, episode (bundled) payment, gain-sharing schemes, and the like.

Relevant OMA Principles:

- Oregon's system should incent physicians and other health care providers to coordinate care.
- Physicians should have leadership roles in creating payment reform models and in the decision making authority over the distribution of shared savings and bonus payments.
- The planning and implementation of payment reform models should include broad participation by physician groups in all practice settings including independent practice, rural and other settings. This work should be conducted in a transparent manner.
- Innovation should be encouraged. Pilot programs should be used to experiment with alternative payment models. However, the pilots need to include a plan for how they are implemented state-wide, and evaluated using scientifically based evidence. Specialty societies that have robust data should be consulted in using those data to create policies and standards.
- Reform models should adequately compensate providers for care coordination and management services, including consultation with other providers and non face-to-face communication with patients.
- Exceptions should be considered for smaller independent offices as they are transitioned to a new payment system.

Recommendation #6: To stop spending an ever-greater share of public and private resources on healthcare, a global health care spending target should be adopted.

Relevant OMA Principles:

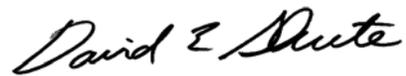
- The OMA supports the goal of controlling and reducing the costs of healthcare.
- An arbitrary limit on health care spending focuses reform on cost containment instead of appropriate value driven care.
- Rigorous cost benefit analysis should be used for all new technology and drugs.
- Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.

What happens when the spending limit is reached? What is the plan for declining care? Rather than establishing an arbitrary spending target, the OHA should focus on eliminating inappropriate care that is not value driven. An arbitrary spending target seems to suggest that

cost containment is the highest priority of Oregon's health reform. While cost must always be considered, the OHA should strive to invest in payment reforms that create a healthier society that is focused on frugal, value-based care, and not cost cutting regardless of clinical outcomes. Congress's attempted implementation of a "sustainable growth rate" in Medicare spending has demonstrated that cost constraints that are not based on individual utilization are not enforceable.

The OMA appreciates the opportunity to comment on this report. We look forward to working with the Oregon Health Policy Board, the Oregon Health Authority and the many other stakeholders on implementing health reform that provides access to high quality care to all Oregonians.

Sincerely,



David Shute, MD
Chair, OMA Committee on Health Care Finance

cc:

Governor-Elect John Kitzhaber, MD
Senator Alan Bates, DO
Bruce Goldberg, MD
Jeanne Smith, MD