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**Joint Interim Task Force on
Primary and Mental Health Care
Reimbursement**

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**Joint Interim Task Force on
Primary and Mental Health Care
Reimbursement Report to the
2015 Legislature**

Executive Summary

In 2013, the 77th Legislative Assembly enacted House Bill 2902 (Appendix A), which established a thirteen-member Task Force on Primary and Mental Health Care Reimbursement, to study payment reform options in support of primary and mental health care, specifically addressing payment parity for physicians, physician assistants, and nurse practitioners in Oregon. The Task Force has been directed to prepare this report recommending an array of potential changes to statute in support of sustainable payment models for primary and mental health care services. The Task Force is scheduled to sunset at the convening of the 2016 Regular Session of the Oregon Legislative Assembly.

The charge of the Task Force is to:

- (a) Study and make recommendations for a payment structure for reimbursement by insurers of licensed physicians, physician assistants and certified nurse practitioners,
- (b) The payment structure must promote the maintenance and expansion of the primary care and mental health care workforce in Oregon
- (c) The payment structure must ensure that all primary care and mental health care providers in these licensed specialty designations are compensated fairly

The Task Force began convening monthly meetings on January 17, 2014. During these sessions testimony was presented concerning:

- Primary Care Workforce
- Patient Centered Primary Care Medical Home
- Behavioral Health Integration Models
- Behavioral Health Workforce Issues- Physician, PA and Nurse Practitioners Perspective
- Insurer Perspective on Payment Reform and the Distribution of Health Care Expenditure
- Alternative Payment Models

The Task Force constructed a set of goals and principles (Appendix B) in the process of understanding the challenges of payment reform in order to organize the findings and recommendations to follow. It is the understanding of the Task Force that while there are many efforts to find ideal payment structures across the country, no single effort has come forth as the ideal. The following report represents the cumulative learning of the four (??) meetings of the Task Force.

Findings Regarding Payment Parity for Physicians, Nurse Practitioners, and Physician Assistants:

Oregon's payer environment prior to the 2013 Legislature passing House Bill 2902 only one payer did not reimburse physicians, nurse practitioners, and physician assistants at the same rates for services provided for and billed using Evaluation and Management (E&M) or Health and Behavior (H&B) coding systems. This inequity only effected a small number of Behavioral Health Nurse Practitioners, but in their practices the effect of decreased reimbursement was devastating.

Testimony clarified the uniform use of the E&M/H&B coding system as it defines a Level of Service (LOS), and hence the payment by:

- Using documentation elements from a visit encounter
- Elements include specific information in history of present illness, review of systems, past

- medical, surgical and social history, as well as physical exam, diagnosis and treatment plan
- Based on the level of complexity a LOS is assigned
- Specific LOS have a graduated fee schedule, increasing with advancing levels of history, examination and decision making
- Providers submit an LOS code for each encounter to an insurer for payment

Testimony pointed out the limitations of the coding systems in truly describing several factors directly and indirectly related to the visit encounter including:

- The LOS does not reflect the level of training, content knowledge, quality outcomes, or cumulative experience of a provider, even within the same licensed specialty
- The LOS is entirely dependent on the ability to document accurately and completely, thus is dependent on the documentation skills of the provider, not necessarily what actually occurred during the visit
- New Electronic Medical Record (EMR) systems often utilize templates for documentation, further questioning the accuracy of a visit's documentation
- Coding rules and requirements are routinely changed in an attempt to improve adequate determination of LOS, which, while potentially helpful, create confusion within the provider community
- The current coding system used in the United States is firmly established and an attempt to use an alternative payment system for Fee For Service billing, unique to Oregon, is not feasible

Testimony also highlighted the differences in training for providers licensed as physicians, nurse practitioners, and physician assistants, as well as the roles the provider types play in the care of patients, including:

- Cumulative years of medical school and residency training for physicians, particularly those with sub-specialty training in Psychiatry, Pediatrics, Addiction Medicine, and Geriatrics
- Cumulative years of training for nurse practitioners, particularly those specializing in behavioral health, geriatrics and pediatrics
- Relationship of physician assistants practicing under the license of a physician
- Importance of cumulative clinical experience in all provider groups

Recommendations: Payment Parity

The Task Force recommends that the 2015 Legislative Assembly:

1. Assure compliance of current statute
2. Remove sunset language from current ORS 743A.036 statute

Additionally, the 2015 Legislative Assembly should task the appropriate regulatory body to provide monitoring of the ongoing fiscal impact of payment parity and its influence on the portion of the mental health workforce most affected, to assure access to mental health care.

Findings Regarding Support for Primary and Mental Health Care Workforce:

The Task Force heard consistent testimony that the shortage of primary care and behavioral health care providers of all types is significant and multi-factorial. The workforce shortage is even more dramatic in

the rural areas of Oregon, particularly for psychiatric physician access. The provider shortage is not unique to Oregon, but testimony implied that it was more profound than in other regions of the country. Common elements contributing to the shortage of providers in these specialties include:

- Low reimbursement for services relative to specialty and procedural care
- Limited training opportunities in Oregon for primary care and behavioral health for physicians, nurse practitioners and physician assistants
- Challenges of serving complex patient populations
- Increasing demands on primary care providers for population management, care coordination, chronic disease care, documentation, and patient education without a corresponding increase in reimbursement
- Large debt burden for physicians coming out of medical school, influencing their choice of residency programs to those specialties with higher income potential
- Limited loan reimbursement programs in Oregon

Testimony given to the Task Force provided several options to address the shortage of primary care and behavioral health physicians, nurse practitioners and physician assistants including:

- Significant increase in overall reimbursement for primary care and behavioral health care services, recognizing the need to keep overall cost of care at or below its current rate of growth
- Payment for services currently not routinely reimbursed in a Fee For Service payment system, such as care coordination, population management, triage care, phone consultation, virtual visits, and bi-directional behavioral health integration
- Movement of payment models to risk-adjusted global payment for primary care and behavioral health services for populations of patients
- Accelerating transformation to team-based care models, particularly uniform implementation of the Patient Centered Primary Care Medical Home
- Increased training opportunities for physicians, nurse practitioners and physician assistants in Oregon
- Expanding loan reimbursement programs and other financial incentives to include all Oregon counties with documented provider shortages
- Address barriers to practice in Oregon for Foreign Medical Graduates in primary and behavioral health care settings

Recommendations: Provider Workforce Support for Primary Care and Behavioral Health

The Task Force recommends that the 2015 Oregon Legislative Assembly:

1. Support all current work of the Oregon Health Authority and Oregon Health Research Council, and other statewide initiatives in tracking provider shortage areas and offering options to address issues influencing the shortage
2. Should develop options for strategic funding partnerships with health systems, insurers, and communities to provide economic incentives to practice primary care and behavioral health in Oregon
3. Expand and fund loan repayment programs to include all communities with provider shortages in primary care and behavioral health
4. Increase funding for residency training programs across Oregon for physicians, and primary care/behavioral health training programs for nurse practitioners and physician assistants
5. Investigate options to remove barrier for foreign medical graduates to practice primary

care and behavioral health in Oregon

6. Mandate cost-based payment for services in support of Primary Care Medical Home, currently not reimbursed including care coordination, registry management, triage services and phone consultation

Findings Related to Alternative Payment Models:

The Task Force reviewed testimony related to multiple Alternative Payment Models (APMs) currently being piloted across the United States. The scope of the Task Force included only primary care and mental health services. Many of the models in study in other states, as well as Oregon, include payment for defined disease states or certain specialty procedures, which though not in scope are important to consider when looking at overall payment reform. Testimony outlined a progression of payment mechanisms from our current Fee for Service toward a Global Payment model, specifically:

- Fee for Service (FFS), payments for visit encounters
- Care Coordination (CC) + FFS
- Practice Transformation Support (PTS) (Triage, Registry, Virtual Care) + CC + FFS
- Shared Savings + PTS + CC + FFS
- Global Payment (SS+PTS + CC + FFS)

Global Payment structures would be paid as Per Member Per Month with a portion of payment tied to quality outcomes, patient experience and cost control (Triple Aim). Patient populations would need to be risk-stratified based on historical utilization data in order to fairly compensate providers for the complexity of their patient panels. Data systems with capability to track populations, monitoring for multiple variables, would be essential for the payers and providers. Provisions of the Affordable Care Act related to technology have been intentional with respect to creating this level of data exchange, but at this point are not uniform across Oregon's health care settings.

Total cost of care for health services continue to escalate nationally, and in Oregon as well. The Oregon Health Authority has targeted a reduction in the rate of cost growth from 4.8% to 2.8% for the Coordinated Care Organizations. Control of total cost of care is critical for a sustainable payment model for Oregon. Consideration for a state-wide, all payer, cap to growth has been considered in several states, including Massachusetts, where state-sponsored insurance was put in place prior to the ACA. Investments in primary care and behavioral health have shown savings in emergency room, hospital, specialty care and pharmaceutical costs.

Recommendations: Alternative Payment Models

The Task Force recommends that the 2015 Legislative Assembly:

1. Define a mandated timeline for a phased transition to a state-wide, all payer, risk-stratified global payment mechanism for primary care and integrated behavioral health
2. Set a target for total health care cost growth reduction, cumulative for all payers across Oregon
3. Convene a multi-payer collaborative to develop the implementation plan for a state-wide payment reform plan for the commercial health insurance marketplace

Additionally, the Task Force recognized the importance of introducing Alternative Payment Methods for specialty care services, notably for episodes of care, bundled payments for certain procedures, hospital services and transitions of care.