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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 meetings testimony was presented concerning:

- Primary Care workforce;
- Patient Centered Primary Care Home;
- Behavioral health integration models;
- Behavioral health workforce issues – Physicians, Physician Assistant (PA) and Nurse Practitioners (NP) perspective;
- Insurer perspective on payment reform and the distribution of health care expenditure; and
- 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 five meetings of the Task Force.

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

Prior to the passage of House Bill 2902 (2013), Oregon's payer environment experienced several payers not reimbursing physicians, nurse practitioners, and physician assistants at the same rates for the same services being provided. The providers used the Evaluation and Management (E&M) or Health and Behavior (H&B) coding system. This inequity particularly affected a number of behavioral health NPs, which resulted in substantial economic impact. Starting in 2009, a number of payers cut reimbursement for non-physician providers, including Psychiatric Mental Health Nurse Practitioners (PMHNPs). Reduced reimbursement had an impact on these providers, and some resigned from certain insurance panels which impacted patient access. While the cuts began in mental health, within a few years several carriers also made reductions in reimbursement for NPs and PAs in primary care. Testimony clarified

the uniform use of the E&M/H&B coding system. This system is used in fee-for-service (FFS) payment structure, for defining the level of service (LOS) provided and the corresponding 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; and
- Providers submit an LOS code for each encounter to the insurer for payment.

Testimony also pointed out the limitations of the coding systems in 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, which may impact the accuracy of a visit's documentation;
- Coding rules and requirements are routinely changed at federal and international levels, in the CPT and ICD-9/10 systems, in an attempt to improve adequate determination of LOS, which, while potentially helpful, create confusion within the provider community; and
- The current U.S. coding system is firmly established and an attempt to use an alternative payment system for FFS billing, unique to Oregon, is not feasible.

Testimony also highlighted the differences in training for providers licensed as Physicians, NPs, and PAs, as well as the roles the other 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 NPs and PAs, particularly those specializing in behavioral health, geriatrics and pediatrics; and
- Both NPs and PAs carry an individual license to practice. PAs work collaboratively with their supervising physicians. NPs and PAs are allowed to bill insurance for services via their NPI numbers.

Testimony from the Department of Consumer and Business Services explained potential mechanisms of monitoring insurers for compliance with the current language of ORS 743A.036. The Task Force has requested a direct survey of insurers, requiring documentation of that assure proper payment of providers. Survey results will be presented to the Task Force in March 2015. Further recommendations concerning fair payment will be issued by the Task Force after analyzing the findings.

Recommendations: Fair Compensation

The Task Force recommends that the 2015 Legislative Assembly:

1. Maintain the sunset language in current ORS 743A.036 as the Task Force continues to evaluate its impact, as well as study the payment reform work currently in process in Oregon with the

intent of recommending legislative concepts in subsequent sessions of the Oregon Legislature;
2. Clarify the definition of "independent practice" as it pertains to billing for services impacted by House Bill 2902;
3. Assure compliance of current statute in ORS 743A.036, requiring payment equity for independent practice providers, supplying primary and mental health care services, using a direct survey assessment of insurers by the Insurance Division, Department of Consumer and Business Services (DCBS);
4. Monitor and report any clinical, financial, and access impacts of the provisions enacted by House Bill 2902 on the physical and mental health delivery system; and
5. Specifically evaluate and address mental health reimbursement practices for non-physician mental health providers including social workers, professional counselors, marriage and family therapists, and psychologist to ensure access to important mental health services with fair reimbursement amounts for all providers.

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 (residency slots, MD/DO/PA/NP degree positions) in Oregon for primary care and behavioral health for Physicians, NPs and PAs. Expanding Medical Residencies is currently under study by the Oregon Health Policy Board's Health Care Workforce Committee(Appendix C);
- 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, PAs, and NPs coming out of training, influencing their choice of residency programs to those specialties with higher income potential; and while loan reimbursement programs in Oregon may be more robust than other states, there may still be opportunity for further incentives to practice in the state.

Several options were presented to the Task Force to address the shortage of primary care and behavioral health physicians, NPs and PAs including:

- Significantly increase the 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;
- Expanding payment for services currently not routinely reimbursed in a FFS system beyond current pilot programs, 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 health care transformation to team-based care models, particularly uniform implementation of the Patient Centered Primary Care Home. Increase training opportunities for physicians, nurse practitioners and physician assistants in Oregon;
- Expand and communicate loan reimbursement programs and other financial incentives assuring

inclusion of all Oregon counties with documented provider shortages; and
- Recommendation that the Health Care Workforce Committee of the Oregon Health Policy Board (OHPB) address possible barriers for Foreign Medical Graduates in primary and behavioral health care settings to practice in Oregon.

The Oregon Health Policy Board's Health Care Workforce Committee is currently evaluating and charged to: coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation, and an increasingly diverse population. The Health Care Workforce Committee focuses its work on identifying resources, needs, and supply gaps, and ensuring a culturally competent workforce that is reflective of Oregon's increasing diversity. The Committee advises, develops recommendations and action plans to be presented to the OHPB for consideration. In addition, the Health Care Workforce Committee receives senior-level staff support from the Oregon Healthcare Workforce Institute, as well as from the Office for Health Policy and Research. The duties of the Committee are to:

- Coordinate efforts to recruit, educate, retain quality workforce;
- Conduct an inventory of all grants and other state resources available for expanding workforce; and
- Establish goals to guide grants awarded from the Healthcare Workforce Strategic Fund.

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 (OHA) and the OHPB's Health Care Workforce Committee, as well as 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 for primary care and behavioral health providers to practice in Oregon;
3. Expand and fund loan repayment programs to assure inclusion of 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 NPs and PAs;
5. Investigate through the Health Care Workforce Committee of the OHPB if any significant barriers exist for Foreign Medical Graduates (FMGs) to practice primary care and behavioral health in Oregon; and
6. Support legislative efforts to provide additional technical assistance for providers in primary care and mental health-focused clinics to adopt new models of team-based care, integrating behavioral health and physical health, such as Patient-Centered Primary Care Home. Areas of practice requiring technical assistance may include registry management, shared care plans, care transition communication tools, patient portals and decision-making tools.

Findings Related to Alternative Payment Models:

Many of the models being studied in other states, as well as Oregon, include payment for defined disease states or certain specialty procedures, which though not in the Task Force scope, are important

to consider when looking at an overall payment reform. The Task Force scope includes primary care and mental health services and received testimony relating to multiple alternative payment models (APMs) currently being piloted across the U.S. Testimony outlined a progression of payment mechanisms from our current FFS system 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 (PMPM) 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 (ACA) related to technology have been intentional with respect to creating this level of data exchange, but at this time are not uniform across Oregon's health care settings.

The Task Force acknowledges the early successes of Coordinated Care Organizations (CCOs) across Oregon in cost containment, emergency services utilization and quality improvement during the first year of operation. It remains unclear as to whether this can be sustained over time, but the lessons learned during this experience over the next 24-36 months will be telling. Proof of a sustainable model in the Medicaid delivery system will help inform the future direction of the insurance marketplace.

Total cost of care for health services continue to escalate nationally, and in Oregon as well. The OHA has targeted a reduction in the rate of cost growth from 5.4 percent to 3.4 percent for the CCOs. Control of the total cost of care is critical for a sustainable payment model for Oregon. Consideration for a state-wide, all payer, capitation to growth has been considered in several states, including Massachusetts, where state-sponsored insurance was put in place prior to the ACA. Thus far, investments in primary care and behavioral health have shown savings in emergency room, hospital, specialty care and pharmaceutical costs.

Testimony from the Center for Evidence-Based Policy, who had been commissioned by the OHA to study Alternative Payment Methodologies in Oregon, concluded with the following five key findings:

1. APMs can be effective in reducing utilization & costs while improving quality of care;
2. Thought leaders understand APM models, support their development & implementation;
3. There is no "one-size-fits-all" model for APMs;
4. Reform decisions need to be made at the local level and involve all stakeholders; and
5. It's all about relationships.

The Center also identified the following six best practices:

1. Invest in relationships;
2. Acquire useable data;
3. Establish strong leadership;
4. Value simplicity;
5. Prioritize a "win-win" agreement; and
6. Persevere.

Further testimony outlined the APMs currently in place in three of the CCOs in Oregon. All CCOs are required by legislation to implement APMs, but these three communities have made substantial changes, which in early analysis look to be promising. Each CCO studied had designed very different mechanisms for payment reform which would work in their community, given its specific demographics, structure and composition. It became clear to the Task Force that there will likely not be one model that will work well uniformly across the state, but each community will need to establish changes that best support the care model in their region. Pay for Performance models studied seemed to have more promise in improving quality and experience. Insurance representatives pointed out the potential differences between the CCO market and the commercial market, but with the stated intention of the Governor's efforts to include the Public Employees Benefit Board and the Oregon Educators Benefit Board in utilizing CCO structures to provide care may change the current dynamic. There was a clear understanding that when insurers needed to work within a budget, the conversation with providers was different, and the level of collaboration increased.

Recommendations: Alternative Payment Models

The Task Force recommends that the 2015 Legislative Assembly:

1. Utilize the OHPB's Sustainable Health Care Expenditures Workgroup (SHEW) to understand high cost drivers and cost trends, working toward setting a target for total health care cost growth reduction, cumulative for all payers across Oregon;
2. Establish the implementation of a multi-payer consensus agreement to institute alternative payment methods for services delivered in a Patient-Centered Primary Care Home or similar team-based care models, specifically including a mechanism for compensating care coordination, behavioral health integration, registry management, triage services and phone consultation;
3. Instruct the OHPB, modeling after the primary care multi-payer agreement process, to study a similar payment mechanism to care for patients established in a behavioral health focused primary care setting, provided that experience in these models, in Oregon and across the U.S., demonstrate sustainable success in outcomes, experience and cost; and
4. Examine any potential health care payment legislation with a lens of flexibility in design, to optimize local community solutions.

Additionally, though beyond its scope, the Task Force recognizes the importance of encouraging the development of alternative payment methods for specialty care services, notably for episodes of care, bundled payments for certain procedures, hospital services and transitions of care. Continued partnership with the OHPB will be critical for successful acceleration of payment model reform. The Task Force will continue to examine the efforts to implement payment reform within the state and nation in the coming year, and make recommendations for legislative action deemed necessary to support the optimal health care model.

Finally, the Task Force recognizes that once it is assured that the intention of House Bill 2902 has been fulfilled with respect to fair compensation, the further work of establishing an optimal primary care and behavioral health workforce, as well as legislating ongoing payment reform, may require merging or reconfiguring the Task Force. The Task Force members remain committed to bringing meaningful change in payment models, with the intention of supporting our providers and best-practice care model design, in order to improve the health of the people of the State of Oregon.