

Incentives and Outcomes Committee
Background Materials & Recommendations to the Health Policy Board
10/12/2010

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I. Staff Background

A. The Challenge

Our health care delivery system is broken. Per capita health spending has risen faster than the consumer price index and personal income for decades, and total health spending consumes an ever-growing percentage of our nation’s gross domestic product. Most health care professionals and institutions lack the information, infrastructure and incentive to ensure that the services they provide and bill for actually improve the health of their patients. As a result, health care is too often of poor quality—not safe, timely, effective, efficient, patient-centered, and equitably provided. Moreover, it is estimated that about 30% of services provided to patients is unnecessary or inappropriate.¹

But we have the delivery system we created and we cannot correct flaws that we cannot identify or measure and that providers lack the incentive to change. Currently, measurement of system and provider performance is fragmented and partial. Moreover, the fee-for-service payment system fails to link payment to achievement of desired outcomes. It pays for units of service and procedures; it does not pay for improving health or delivering superior quality and efficiency. It rewards hospital admissions and expensive procedures; it does not reimburse for care coordination, discharge planning, and other activities that are critical to keeping people healthy.

The delivery system is in urgent need of change. Key change strategies will include measuring quality and efficiency and deploying payment strategies that hold all participants in the system accountable for improvement.

B. Charge to the Committee

To assist with addressing the delivery system transformation challenge, the Health Policy Board established an Incentives and Outcomes Committee, charging it to make recommendations relating to quality improvement and payment strategies.

The committee's charter calls on it to:

- Make recommendations to the Board about and continually refine uniform, statewide health care quality standards in support of a high performing health system and the further development of value-based benefit design for use by all purchasers of health care, third-party payers, and health care providers;
- Adopt principles for payment; and
- Develop recommendations to the Board for transparent payment methodologies that provide incentives for cost-effective, patient-centered care and reduce variations in cost and quality of care.

This report provides the committee's initial recommendations made in response to the charge above. The strategic recommendations are preceded by the committee's overall vision or delivery system transformation (see below) and followed by staff recommendations on concrete action steps for implementation (see page 14).

C. An Oregon Strategy to Reach the Triple Aim

Delivery system transformation is necessary to reach the triple aim goals of lifelong health; increased quality, reliability, and availability of care for all Oregonians; and lower costs so that care is affordable to everyone. Transformation will be a product of collaborative efforts to continuously improve the quality of care for individuals and the performance of the system as a whole.

The transformed delivery system should function within a clear total system budget that reflects both the costs of providing care and the capacity and willingness of society to pay—e.g., does not continue to absorb an ever-greater share of private and public resources. It should ensure that access to evidence-based care is not differentially granted or denied particular individuals or populations based on factors unrelated to medical need. This system should:

- Foster provider accountability through a mature measurement infrastructure that provides meaningful, accurate, and actionable data on delivery system performance at the provider, practice, and institutional levels;
- Measure provider performance on both health outcomes and cost metrics relative to historical performance, peer performance, and explicit benchmarks; and
- Include a payment structure that initially rewards performance and ultimately is tied to the budgeted cost of efficient provision of necessary care.

Ultimately, providers will be capable of and responsible to be wise stewards of limited health care dollars working in partnership with patients who are empowered and supported to make health care decisions consistent with their values.

This transformation will not be instantaneous; it will be a process. Some provider organizations—particularly the integrated systems--will be able to respond very quickly to information on performance and changed incentives, but others will require more

support and time. Neither implementing silo-ed quality initiatives nor changing payment incentives will instantly result in the provider and system behavior change that will improve health outcomes. A realistic transformation strategy must include five key elements:

- Payment incentives strong enough to overcome ingrained medical culture;
- Strategic, targeted quality measurement and improvement initiatives;
- Support for change in medical practice and business strategy;
- Meaningful involvement of patients, families, and communities; and
- Time for adjustment.

In the short-term, transformation efforts should focus on:

- Building provider capacity to organize and restructure care processes, coordinate care, and use data to deliver care more effectively and efficiently;
- Increasing patient engagement; and
- Aligning improvement efforts across the system.

During this phase, the state should standardize and align payment methods and experiment with new payment methodologies—in the process building provider capacity to coordinate care and improve care processes.

In the medium-term, we will learn from payment experience, strengthen accountability, and improve tools for setting efficiency targets.

In the long-term, payers will migrate toward payment methods that place greater constraints on spending and responsibility on providers to help allocate spending for greatest benefit to patients.

D. Delivery System Reform Cannot Wait

Change is hard. Oregon will be asking providers and facilities to work with us to avoid things that—in today’s payment environment—produce revenue: Unnecessary office visits, unnecessary procedures, preventable hospital admissions. That means reduced income for some providers. We believe that once providers and facilities learn to reduce their costs, they can share in the savings; but it is very hard for them to choose to be a part of a project that puts at risk the fee-for-service income stream they have counted on.

But now is a unique moment. Beginning in 2014, far more Oregonians will have insurance coverage due to passage of the federal Accountable Care Act. An increase in coverage will likely produce an increase in overall health service utilization. This will bring more revenue to providers, cushioning the blow they might otherwise experience as unnecessary utilization declines. It is a triple win (Figure 1):

- Purchasers: Lower costs for purchasers through both the elimination of the cost shift and the improvement of the quality and efficiency of care.
- Providers: Stable revenue for providers who will have patients and opportunities for rewards for providing good care efficiently.
- All Oregonians: The right care, at the right time, at the right price.

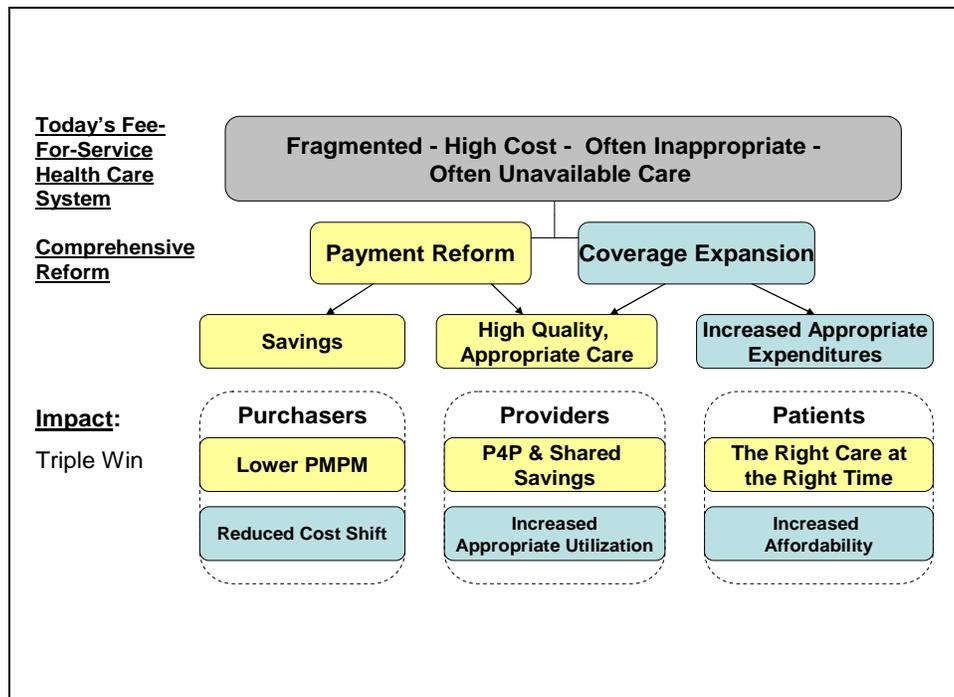


Figure 1. The Triple Win

II. Committee Recommendations

Oregon's health care system is unsustainable. Many professionals and institutions lack the information and infrastructure to ensure that the services they provide actually improve the health of their patients. Current financing and payment mechanisms (such as fee for service) contribute to the problems of the system by failing to link payment for health care goods and services to achieving desired outcomes. The transition from current payment mechanisms to those that will support a sustainable health care system must be grounded in transparent measurement of outcomes supportive of the Oregon Health Authority's Triple Aim goals and should be guided by the principles of equity, accountability, simplicity, transparency, affordability, and transformation.

The committee has made six recommendations designed to support the transformation to a sustainable health care system for Oregon. In addition, the committee identified the following as necessary elements of each recommendation:

- Demonstrate the business case for the reform effort, outlining the expected health improvement outcomes and why the reform makes financial sense for the OHA and the larger health system;
- Develop concrete implementation steps, processes, and timelines; and,
- Develop measurement capacity and evaluation programs so that the Board and state can see if the projected business case is playing out, including whether health improvements are being achieved.

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

What: Adoption of a standard payment methodology is the first step Oregon must take to restructure payment for value. Medicare offers the most reasonable payment method to adopt for hospital, ambulatory surgery, physician and professional services, except services billed by critical access hospitals or type A and B hospitals. Standardization of payment methodologies is a vital foundation for aligning incentives for payment methods such as episodes of care or other accountable payment methods and an important an important measure to reduce administrative cost.

How: A new statutory requirement should be enacted in 2011, effective in 2012 when Medicare's updated rules go into effect for the particular provider type (e.g. October 1 for hospitals). The standard payment method for Oregon would change as Medicare methods change. The statute would clearly state which elements of Medicare's payment methodologies are adopted in Oregon and what deviations, if any, are permitted.

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

What: Primary care homes as described by the Patient Centered Primary Care Home Standards Advisory Committee final report are fundamental to achieving the triple aim and should be rolled out as aggressively as possible. This will require the involvement of all payers and primary care providers.

How:

- The Health Policy Board should adopt the Patient Centered Primary Care Home Standards and the Committee's proposed structure for aligning payments to tiers within those standards as the model for primary care redesign in Oregon.
- The Oregon Health Authority (OHA) should sponsor development of measurement and evaluation systems and infrastructure for implementing the standards as a basis for payment.
- The OHA and other payers should immediately restructure primary care payment, aligning with the standards framework. It is recognized that payers may pay at differing levels for attainment of the same levels of performance and that practices will become robust primary care homes at varying speeds.

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.

What: The primary emphasis of the first phase of work to improve quality and reduce cost should be eliminating the most significant defects in care. 'Defects' is a broad term

that includes over- and under-utilization, lack of safety, uncoordinated care, and other examples of poor quality, inefficiency or unreasonable cost.

How:

- Both elements of the Committee have made initial recommendations of focus areas. The Quality and Efficiency Subcommittee has suggested readmissions, low back pain, cardiac care, healthcare acquired conditions, and care coordination, among others, and the Payment Reform Subcommittee has identified cardiac conditions, orthopedic conditions, and cancer treatment. See Attachment 1 for a side-by-side comparison of potential targets.
- Further technical work should begin immediately to finalize these initial proposals as OHA recommendations for common focus areas and to link them with payment.
- Payers, purchasers, providers, and patients should adopt the recommended common focus areas for measurement and payment work to increase the impact of their efforts. In selecting focuses, primary emphasis should be given to potential for reducing costs and eliminating defects, while giving consideration to potential for reducing inequities and aligning with national and local initiatives.

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

What: When patients and families participate as full partners with healthcare professionals to improve their health, system performance improves. A truly patient- and family-centered system will structure services and care to support the patient and family to be full members of the healthcare team. Responsibility for patient engagement should be clearly articulated and allocated among providers, patients, and plans. Evaluation of the success of efforts to increase patient- and family-centeredness should touch the domains of patient and family involvement, support for patient self-management, use of evidence-based shared decision-making tools and processes, coordination of care, respect for patient values, and organizational attention to the patient experience of care.

How:

- This dimension has been built into primary care home standards and should be extended to other parts of the system through the design of new payment systems and other mechanisms.
- To accelerate patient engagement efforts, common measures of patient experience and engagement should be developed and deployed across the system.
- To build provider capacity in this area, OHA should lead efforts to extend an existing learning network that provides technical assistance to organizations to help them learn how involve patients and families as advisors.

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

What: Migrate as rapidly as possible away from exclusively fee-for-service provider payment systems and toward systems that reward desired structures, processes, and outcomes and systems that incent providers to coordinate care, eliminate care defects, and drive unnecessary costs out of the system. To ensure successful transition to new payment methods, it will be necessary to build provider capacity to restructure their practices to respond effectively to new payment incentives.

How:

- The OHA and other payers should pilot new payment programs (or align with and expand existing ones), including pay-for-performance and episode payment programs, cooperating to achieve critical mass sufficient to support and incent delivery system change.
- To accelerate widespread adoption of common priorities and measures, OHA should provide leadership by setting priorities and measures and using them in all of its programs.
- Payment pilot programs should test the value of service agreements and patient engagement strategies and should address a range of clinical issues based on an assessment of potential for measurable delivery system improvement.
- Pilots should be designed to facilitate rigorous evaluation of the payment innovation and to provide feedback to physicians and the public on provider performance.

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

What: The Health Policy Board should set a spending target that limits growth of health care spending to growth in a measure of overall consumption or income such as the consumer price index. Aggressive action should be taken to keep spending within the target.

How:

- The Health Policy Board should set the spending target and monitor system performance relative to the target.
- The OHA should develop improved measures of delivery system efficiency.
- The OHA should develop benchmarks for the cost of delivering high quality care efficiently that are based on rigorous examination of the evidence.
- Payers should use benchmarks to set cost targets and payment levels.
- The business case (in terms of expected improvement in health outcomes and system cost) should be demonstrated for all programs and technologies, beginning with new proposals and eventually extending to existing practices.

III. Subcommittee Process and Recommendation Development

The following section provides context and further background information on the development of the short-term policy recommendations made by the Incentives and Outcomes Committee of the Health Policy Board.

A. Quality Measurement in Support of Improvement

Performance measurement can identify and highlight defects in care: over- and under-utilization, lack of safety, uncoordinated care, and other examples of poor quality or inefficiency. Measurement and feedback are critical first steps for broad-based quality improvement efforts.

In its initial body of work, the Quality & Efficiency Subcommittee identified measurement priorities and potential indicators to inspire the work of its sister subcommittee and private sector groups by providing measureable targets for payment reforms. Measurement priorities and potential indicators were selected with the following considerations:

- A focus on measures that would be feasible to implement immediately and that would align with or build on the measurement efforts of local and national partners;
- A desire to balance the benefit of measurement against the burden it may create for providers and healthcare systems; and
- A strong appreciation for the value of having a mix of quality measures: measures of the conditions under which care is provided (structural measures); measures of the processes of care; and outcome measures focused on changes in health status or cost attributable to care provided. This categorization of measures is known as the Donabedian typology.

Measurement priorities and related indicators were identified both within and across settings of care:

1. Patient- and family-centeredness

In a redesigned healthcare system that aligns payment with value, the degree to which patients and families are meaningfully engaged in their care will be a critical factor for success. When patients and families participate as full partners with healthcare professionals, both system performance and the patient experience of care improve significantly. The Quality & Efficiency Subcommittee recognized six distinct domains of patient- and family-centeredness:

- Patient- and family engagement
- Self-management support
- Shared decision-making
- Respect for patient values, preferences, and expressed needs
- Care coordination; and
- Organizational attention to the patient experience of care

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The Committee has made specific recommendations (see page 6) for next steps to improve patient and family-centeredness including establishing standards for measurement of patient experience of care/engagement and developing the capacity of provider organizations to involve patients and families as advisors in all aspects of care delivery. In addition, the Committee recommends measurement of patient- and family engagement and inclusion of related tools and strategies in relevant payment reforms.

2. Hospital and specialty priorities

Quality & Efficiency Subcommittee recommendations for short-term measurement priorities in the hospital setting are:

- Skin injuries (pressure ulcers) and falls because of their frequency, the potential for synergy with national work and partnerships with nursing leadership in the state, and the high cost of care related to these safety failures;
- Readmissions, because these are an indicative of shortcomings in care coordination within and outside the hospital;
- Healthcare acquired conditions because of national and state momentum and the opportunity to advance quality in this area through NSQIP, the National Surgery Quality Improvement Program; and
- The areas of care covered by CMS's core process of care measures: heart failure, heart attack, pneumonia, and surgical safety.

In the area of specialty care, the Subcommittee recommended strengthening system and provider capacity to measure appropriate use of:

- Imaging
- Treatment for low back pain
- Maternity care (particularly cesarean sections)
- Joint replacement
- Cardiac diagnostics and percutaneous coronary interventions

Further technical work is needed to specify how measurement would occur and to link these topics to payment. However, these focus areas align with thinking in the Payment Reform Subcommittee and would create synergy with local and national efforts. The topics listed above represent the Committee's suggestions of the most fruitful starting points for payment reform pilots in hospital and specialty care.

3. Primary care priorities

The Committee strongly supports the primary care home model as articulated by Oregon's Patient-centered Primary Care Home (PCPCH) Standards Advisory Committee in March 2010. The PCPCH Committee identified six core attributes of a primary care home and articulated number of standards that describe how care delivered by a primary care home would embody the core attributes. In addition, the Committee developed a detailed set of patient centered primary care home measures. The six core attributes, with patient-centered language explanations, are:

- Access to care (be there when I need you);

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- Accountability (take responsibility for making sure I receive the best possible health care);
- Comprehensive whole person care (provide or help me get the health care and services I need);
- Continuity (be my partner over time in caring for my health);
- Coordination and integration (help me navigate the health care system to get the care I need in a safe and timely way); and
- Person and family centered care (recognize that I am the most important member of my care team and that I am ultimately responsible for my overall health and wellness).

The full report can be found online at:

http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf.

For initial measurement and implementation, the Quality & Efficiency Subcommittee suggested prioritizing the following standards of each attribute:

- Access: in-person (appointment) and telephone access, followed by electronic access
- Accountability: tracking and reporting of clinical quality indicators, followed by improvements in medication management practices
- Comprehensiveness: provision of behavioral health care
- Continuity: linking patients with a personal clinician or care team
- Coordination: capacity for care planning, followed by evidence of the primary care home's connection to the larger medical neighborhood

Development of a measurement system and support infrastructure for primary care home implementation is one of the Committee recommendations for transforming primary care. The priorities suggested above, along with others identified by the Payment Reform Subcommittee, may serve as an entry-level set of standards for immediate implementation.

B. Transformation of Provider Payment

1. Principles for Provider Payment

The Committee believes getting payment incentives right is a critical element of the transformation project. Its payment reform subcommittee developed detailed principles for a reformed payment system, which are attached as Exhibit #1. In short the guiding principles for the Committee's work became:

- Equity
- Accountability
- Transformation
- Cost Containment
- Simplicity
- Transparency.

2. The Transition Path

The Committee believes that for most providers, the path from fee-for-service payment to comprehensive payments will traverse some intermediate ground wherein providers are paid in a mix of ways. During the intermediate phases, we expect payers to use the following types of payment:

- “Pay-for-performance” incentive payments: These payments are built on a fee-for-service base to reward structure, process, or health outcome achievements. Incentive payments are often calculated as a percentage of the underlying fee-for-service payment. They may result in increased total provider payments. But a payer’s total cost may be kept neutral by reducing base fee-for-service payments payment and using the savings to create an incentive payment pool from which incentive payments can be made to top performers.
- “Shared savings” payments: Shared savings are also built on a fee-for-service base. If a provider or group of providers keeps costs of care below a target while maintaining or improving quality standards, the insurer or other payer may allow the provider to keep a portion of the savings—thereby encouraging coordination or care and efficiency.
- “Bundled” or “episode” payments: A bundled or episode payment is a single payment for all services connected to an episode of care such as a hospital admission for a surgery and post-acute care or a year’s care for a diabetic patient; the payment covers services performed by multiple providers in multiple settings, thereby encouraging coordination of care and avoidance of unnecessary re-admissions.
- “Primary care base payments”: Payments to support primary care practices’ infrastructure development, care coordination, patient engagement, and other activities that the current fee-for-service system does not reimburse. The base payment would also include reimbursement for provision of a bundle of primary care services.

The Committee’s vision for the transition from fee-for-service to more comprehensive, outcomes-oriented payment models is illustrated below for three major categories of providers: primary care practices, specialty practices, and hospitals. Some providers may have the capacity to move more quickly along the path than others. Carrying out the transition process is further complicated by the reality that Oregon providers function in relation to an array of payers of which the Oregon Health Authority is only one. They therefore respond to incentives created by multiple payment systems. Our goal is for all payers to re-configure their payment policies in according with the framework discussed below.

Primary care practices need to take on greater responsibility for care coordination and management, prevention, and support for patient engagement. To take on these new roles practices will incur new expenses such as salaries for nurse case managers and costs of implementing electronic medical records systems, which cannot be recovered by billing

traditional codes. The payment system will need to support those changes through a system of “patient-centered primary care base payments” that could take the form of enhanced rates for billed services or, more likely, risk-adjusted per member per month health plan payments. The Committee envisions that base payments will grow over time to replace fee-for-service payment for preventive and routine care services in addition to continuing to support the primary care home infrastructure and non-billable services.

In addition to the base payment, primary care practices will receive some of their payment in the form of “pay-for-performance” incentive payments that reward achievements not covered under the base payment; “bundled payments;” and “shared savings” payments. Until the fee-for-service model is entirely replaced by something else, primary care practices would also be paid fee-for-service payments for procedural services to encourage providers to practice to the “top of their license”.

The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 2.

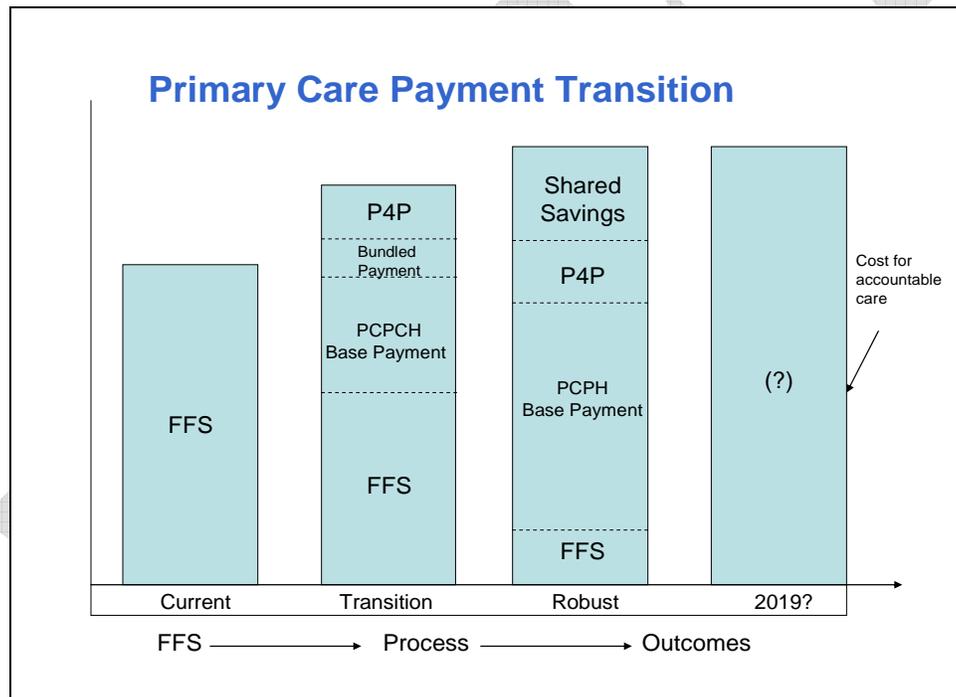


Figure 2. Primary Care Payment Transition

Specialty provider practices will also need to change. In a reformed delivery system, they will coordinate more closely with both primary care practices and hospitals and other care facilities. They will be asked to provide greater support to primary care to manage chronic conditions without unnecessary referrals and to work with hospitals to reduce costs of hospital admissions and avoid preventable admissions. They will be asked to involve patients more in decision-making about their care, which we expect to reduce variation in utilization of certain kinds of procedures that are over-utilized in Oregon relative to the rest of the country. Reimbursement dollars will gradually move away from

the fee-for-service bucket to pay-for-performance, shared savings, and bundled payment buckets. Payers using bundled payment methods may wish to support increased coordination by paying specialists on a fee-for-service basis for advising primary care physicians and other work that is not currently reimbursed.

The committee expects there to be a decline in payments to specialists, as a percentage of total health care spending. This reduction in revenue to specialists will be mitigated by increases in utilization related to increases in coverage supported by federal health reform. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 3.

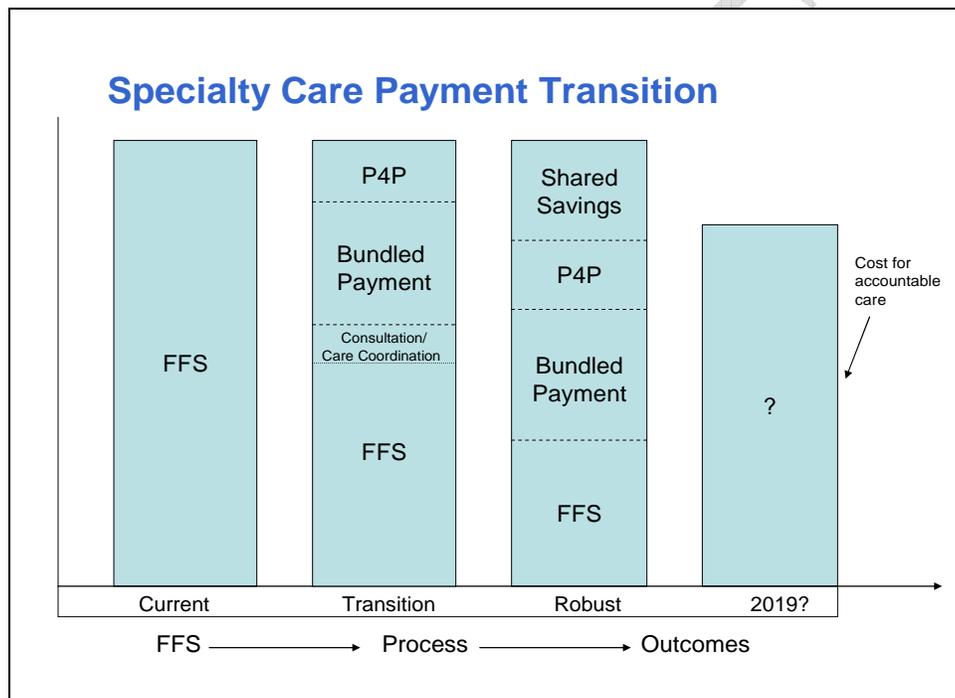


Figure 3. Specialty Care Payment Transition

Hospitals, like specialty care practices, will need to coordinate more closely with providers in other settings to improve quality and efficiency. Whereas the bulk of hospital payments are currently paid on a fee-for-service basis, as a percentage of charges, hospitals should eventually be paid primarily on a bundled basis. Bundles should be constructed so that hospitals no longer make money from readmissions but rather must “guarantee” their work for a period following a patient’s discharge.

The committee expects there to be a decline in payments to hospitals as a percentage of total health care spending, as transitions of care improve, unnecessary hospitalization is avoided, and services are provided in the least intensive setting consistent with good health outcomes. The transformation from fee-for-service to a new form of payment that covers the cost of efficient, effective care is illustrated in Figure 4.

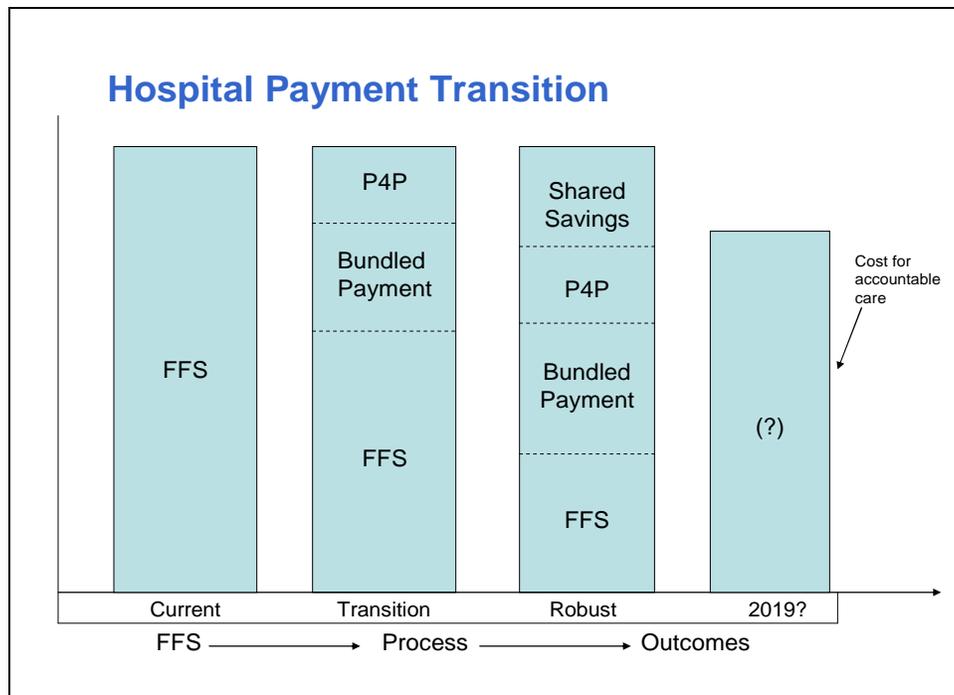


Figure 4. Hospital Payment Transition

IV. Next Steps in Quality and Efficiency Measurement and Payment Reform

Staff Recommendations for Action by the Oregon Health Authority (not reviewed by the committee)

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

Short-term

2010

- Convene work group to flesh out details, including exceptions that allow room for episode payment and other more comprehensive payment methods

2011

- Introduce legislative measure
- Develop method to predict cost/benefit and measure actual administrative savings from standardization

2013

- Changes effective January 1

Medium-term

- Evaluate the program (2014)

- Make recommendations on the value likely to come from standardizing additional provider payments to Medicare (2015)

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

Short-term

2010

- Adopt Patient Centered Primary Care Home (PCPCH) standards and proposed structure to align payments to the tiers
- OHA (Medicaid, PEBB, OEBC, OMIP) participates in Health Leadership Council multi-payer pilot
- Sponsor development of measurement and evaluation systems and infrastructure for implementing the standards as a basis for payment
- Initiate design of regional expansion of primary care homes across OHA populations and care settings (e.g. private practice and community health centers) building in appropriate methods for compensating providers

2011

- Develop learning collaborative for OHA providers to prepare for primary care redesign
- Begin PCPCH implementation in regions with high percentage of OHA lives and where OHA can leverage enhanced Medicaid payments authorized by the ACA

2013

- Evaluate medical home pilots, including ROI, patient and provider satisfaction, improvement in health outcomes; refine PCPCH program as necessary
- Require all OHA plans and providers to implement PCPCH and develop strategy to ensure statewide adoption of PCPCH

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.

Short term

2011

- Conduct technical work necessary to support selection of common focus areas and measures and to link those with payment. Criteria for targeting to include impact on cost or quality, feasibility, potential to address disparities, and opportunity to create synergy with local or national efforts.
- Actively foster multi-payer alignment on common focus areas for measurement and payment. (2011-12)

2013

- Incorporate metrics into OHA contractual programs for performance improvement, pay-for-performance, and bundled payment (see #5).

Medium term

- Continually assess, revise, and expand priorities for efforts (2014-ongoing).

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

Short-term

2011

- Develop recommendations for statewide standardization of patient experience of care and engagement measures

2012

- Lead efforts to extend an existing learning network to increase provider capacity in patient- and family-centered care and to assist organizations to learn how to involve patients and families as advisors.

2013

- Require measurement of patient experience of care/engagement across OHA contracted providers
- Extend focus on patient and family engagement beyond primary care to other parts of the system through the design of new payment systems and other mechanisms

Medium term

- Develop web-based mechanism to assist smaller organizations in collection of patient experience of care/engagement data (2014)
- Evaluate effectiveness of patient and family engagement efforts (2015)

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

Short-term

2011

- Establish P4P metrics and benchmarks to be used across OHA; aligning with Medicaid and Medicare P4P metrics where possible
- Define 5-10 bundles for services where there is high opportunity for improvement in quality/cost/equity/learning and identifies services required to deliver the bundle without defects (2011-2013)
- Determine whether there is a business case for aligning with Medicare by discontinuing payment to hospitals for hospital acquired conditions (“never events”)
- Develop payment rules that mean physicians as well as hospitals are not paid for hospital acquired conditions (2011-2012)

2012

- Develop contractual language and administrative rules to discontinue payment to hospitals for hospital acquired conditions
- Align and expand P4P programs within and across the OHA

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- Actively foster multi-payer alignment on metrics used in OHA for P4P programs.
- Develop a payment reform pilot evaluation protocol, including a system for sharing findings across payers
- Establish a method for aggregating and disseminating data on provider performance, including a trusted party to do the work

2013

- Pilot episode payments, to include service agreements, in areas with high percentage of OHA lives and/or where alignment can be achieved with other payers

Medium term

- Evaluate experimental programs (2014-2015)
- Consider standardizing P4P metrics and episode bundles that may be used in payment in Oregon (2015)
- Develop benchmarks for efficiency and the total cost of care across all settings (2015)

6. To stop spending an ever-greater share of public and private resources on healthcare, adopt a global health care spending target.

Short term

2011-13

- Develop improved measures of system efficiency hospital, specialty, and primary care
- Develop benchmarks for the cost of delivering high quality care efficiently that are based on rigorous examination of the evidence

Medium term

- Evaluate ROI, patient and provider satisfaction, improvement in health outcomes and refine performance measurement systems as necessary (2015)
- Use benchmarks to set cost targets and payment levels. (2015-17)

¹ IOM, National Academy of Engineering, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: National Academies Press; 2005.