

**Oregon Incentives & Outcomes Committee  
Meeting Summary**

September 22, 2010

1:00pm – 4:30

Committee Members in Attendance

Mike Bonetto, Health Policy Board liaison  
Denise Honzel, Co Chair  
John Worcester, Co Chair  
Bart McMullan, Payment Reform  
Subcommittee Chair  
Glenn Rodriguez, Quality & Efficiency  
Subcommittee Chair  
Chris DeMars  
Morgan O'Toole  
Ken House (by phone)

Jim Russel (by phone)  
Mary Minniti  
Nancy Clarke  
Rachel Solotaroff, MD  
Joe Zaerr  
Steve Jasperson (by phone)  
Tom Syltebo  
Jim Kahan  
Stephanie Dreyfuss (by phone)  
William Murray (by phone)

Committee Members not in Attendance

Laura Etherton  
Megan Haase  
David Labby  
William Olson  
Rick Wopat  
Seth Bernstein  
Robert Marsali

David Schlactus  
Brett Sheppard, MD  
Jim Russell  
Dan Clay  
David Dorr  
Dick Stenson  
Sujata Sanghvi

OHPR and OHA Staff in Attendance

Jeanene Smith  
Gretchen Morley  
Lynn-Marie Crider

Nicole Merrithew  
Lisa Angus

Welcome

John Worcester opened the meeting at 1pm. Introductions were made.

John gave an overview of the meeting agenda, noting that the goal was to come to agreement on the Committee's combined recommendations. He reviewed the Committee's charge, which is 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 to further development of value-based benefit design for use by all purchasers of health care, third-party payers and health care providers; 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.

He noted that the Board was expecting the Committee to make clear, concrete recommendations and to outline the estimated cost impact and potential return of those recommendations.

**The July meeting summary was accepted as submitted.**

Updates

Gretchen Morley noted that a newly formed Health Equity group, staffed by the Office of Multicultural Health and Services in OHA, is reviewing work emerging from each of the Health Policy Board Committees and from some technical workgroups such as that of the Insurance Exchange. Similarly, the Safety Net Advisory Council and Medicaid Advisory Committee are reviewing Committee work with an eye on the potential impact for vulnerable populations, including Medicaid recipients, and safety net providers. OHP staff will feed comments from those two review processes back to Committees and the Board. There was some brief discussion of whether one or both groups might be asked to look at risk adjustment for measurement and use of measurement for payment. Since those groups were not assembled with that technical expertise in mind, the issue of risk adjustment was noted for follow-up.

*[Note: the following summary deviates slightly from the sequence of discussion at the meeting]*

Invited and Public Testimony

Craig Hostetler of the Oregon Primary Care Association presented payment reform-related recommendations from the Commonwealth/Qualis safety net medical home initiative in Oregon. Recommendations included:

- Specific patient-centered primary care home (PCPCH) payment mechanisms should be developed for FQHCs and RHCs, who currently receive a bundled payment through Medicaid
- To help clinics transition to a PCPCH model, transition incentives should be provided, such as:
  - Payment for physical and behavioral health visits on the same day
  - Incentives for coordination with other parts of the system
  - Support for EHR adoption
  - Reimbursement for unique work of the medical home (panel management, etc.)
- Final value-based payment structure for PCPCHs should have the following characteristics:
  - Move away from productivity model to paying for outcomes, with appropriate risk adjustment/stratification that includes social factors, not just medical conditions
  - Assure patient-centered care
  - Minimize provider administrative burden
  - Be applied to all patients

Subsequent discussion included the following points:

- Mr. Hostetler believes that much of the project's experience with PCPCHs is applicable outside the safety net
- The project is seeing some encouraging movement in overall costs but it is early yet and participants are not yet doing gain-sharing
- There was some disagreement on the question of whether the kind of primary care transformation described could be accomplished by practice's reallocating how they deploy current payments only or whether both payment increases and payment reallocation are required

No public testimony was offered.

#### Discussion of combined recommendations

Committee members walked through a draft (strawman) presentation of joint Committee recommendations that was an attempt to link proposals emerging from the two Subcommittees. The vigorous discussion is presented here in terms of five points of agreement/recommendation that emerged, followed by some additional considerations and notes on unrelated items.

The Committee identified the following three items as minimum next steps for each recommendation:

- Build the business case 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,
- Identify an expectation for strong evaluation so that the Board and state can see if the projected business case is playing out and health improvements are being achieved

#### **1. Standardize payment method—not price—to Medicare for hospital inpatient and outpatient, ASCs, and physician and professional services.**

- No disagreement on proposed method (statute) and timing (hospitals and ASCs in October 2012, physician services not yet determined)
- Notes:
  - Oregon would be bucking its own and national trends in hospital payment, since DRG payment is in decline
  - There may be push-back from plans and hospitals who currently have multi-year contracts that they think are good deals and don't wish to renegotiate their terms to conform with Medicare payment method
  - Tracking and evaluation are needed to see if the anticipated savings from standardization & simplification are actually being captured

#### **2. Focus measurement and payment efforts in areas where the potential for improvement is greatest - areas of high variation, large cost impact, and significant defects in quality of care.** (Incoming recommendation was to align with Medicare on non-payment for hospital acquired conditions--never events--by not paying hospitals or physicians for additional

services in such cases and using Medicare's pay-for-performance metrics in pay-for-performance programs in Oregon)

- Work still needs to be done to decide what the greatest defects are. Committee members were willing to say that Medicare's focus areas may be a good foundation but noted that Oregon may want to go somewhere different or farther than Medicare. The Quality Subcommittee's priority areas provide a place to start but additional due diligence may be needed to more accurately estimate the scope of the problem, whether the issue is worth tackling, and what the right approach is.
- There was some support for the proposal that payers not pay for never events. However, there was objection to the proposal also, particularly if extended beyond hospitals (where the Medicare policy applies) to physicians. Objections included complexity of application to physicians (so that the concept was not ready for prime time), cost shift in non-profit hospital environment, opinion that loss of revenue often isn't large enough to incent change, and that cost impact of driving out never events is minimal, since they are already infrequent according to some while not trivial according to others.
- There was, however, general agreement on the principle that the goal is eliminating defects and on the idea that organizational work done to eliminate never events at the provider level is important and has benefits beyond never event occurrence.
- There was also support for payers using common metrics in P4P programs—see below.

**3. Encourage system to become more patient- and family- centered**

- There was relatively little specific discussion in this area. However, the Committee agreed that patient- and family-centeredness was important, should be a short-term not a long-term goal, and that the recommendation needed more work. Staff will work with Mary Minniti, who led the group of Quality & Efficiency Subcommittee members looking into patient-centeredness, to flesh out at this recommendation.
- Note: Some specificity for this recommendation can be lifted from Exhibit 8 of the meeting materials (draft next steps for Quality & Efficiency), including but not limited to:
  - OHA partners with Quality Corporation to extend learning network/provision of technical assistance to organizations to help them learn how involve patients and families as advisors. (2011)
  - OHA requires all contracted providers or provider organizations to measure patient experience of care/engagement using forthcoming CAHPS measures that capture key domains of patient and family engagement. Note: CAHPS measures are public domain but the entire survey methodology must be followed to use the CAHPS name. (2013)
  - OHA provides a web-based mechanism to assist smaller organizations to survey patients. (2013)

4. **Move forward decisively on primary care redesign** (incoming recommendation was to pilot primary care homes, a recommendation that received pushback due to lack of aggressiveness)
  - This is a critical first step in achieving the future “desired system” therefore we need to roll-out as aggressively as possible and take an approach that includes plans and providers.
  - Adopt Oregon Patient Centered Primary Care Home (PCPCH) standards as the model for Oregon.
  - Implement them across the board, in the sense that these are the standards that everyone uses, recognizing that not all payers will pay for primary care homes immediately and practices will progress at varying rates through levels of performance.
  - The group did not specify a particular payment model to use in implementation
  - Development of a measurement system for the PCPCH standards and strong evaluation of the impact of PCPCH homes on cost, cost efficiency, quality, etc. will both be key.
  - The group agreed that we need to move away from a siloed payment system and need to find a way to represent this other than specifying that we are moving toward an Accountable Care Organization model. There needs to be further discussion around what the “2019” model (as currently depicted in the payment transition slides) should be.
  
5. **Experiment with different payment incentives or methodologies (P4P, episode bundles, gain-sharing schemes, etc.)**
  - Encourage pilots that have critical mass of participation, consistent measurement standards, and that are well evaluated
  - P4P experiments may need to start with structural or process measures and then move to outcome. Risk adjustment will be crucial when heading to outcomes.
  - P4P programs should use common metrics, aligning with Medicare and within Oregon. This is important for the programs to be effective and to minimize administrative burden on providers. There was considerable discussion on how this alignment might be achieved. At a minimum the group agreed that the OHA could lead toward alignment by using the same P4P programs and metrics in all of its health coverage programs.
  - Episode pilots should be conducted to create payment incentives for care coordination and elimination of defects.
  - Clinical targets for these pilots were not explicitly discussed but many potential targets have been identified by both Subcommittees and staff. Committee members did not express a strong desire to decide on a small number of clinical targets. Some suggested that target-setting should be done in a fact-intensive way as pilots are developed—not by committee.
  - Some of the care coordination and patient-centeredness efforts that were expressed as stand-alone recommendations in the Payment Reform

Subcommittee's document (Exhibit #7) should be incorporated into this recommendation, i.e.:

- Service agreements are valuable tools for better care coordination and should be for a component of episode payment pilots; they should include responsibility for patient engagement. It was also noted that a contract (or service agreement) alone may not lead to the desired change in service delivery. This concept, along with other care coordination initiatives, need to be tied to hospital re-admissions in order to assess effectiveness.
- Incentives for use of shared-decision making tools should be included in P4P schemes or episode pilots focused on preference-sensitive conditions
- There are other recommendations from the patient-centeredness workgroup of the Quality & Efficiency Subcommittee that could be included here as well (see Quality & Efficiency Subcommittee meeting materials from September 9, 2010).

#### *Quality measurement priorities*

The measurement priorities or topics outlined by the Quality & Efficiency Subcommittee (slide 4) represent an opportunity for Oregon to adopt a common set of measures and shared priorities for all of healthcare – OHA and the private sector. The Subcommittee has not fully discussed if common standards should be disseminated via OHA influence or via mandate (legislative or otherwise) and there may be strategies between those two endpoints. It was noted that these measurement areas are more representative of what is achievable now as opposed to what the ideal measurement system would look like; however this may be a good starting point.

#### *Strategies to advance measurement (slide 5)*

This material is tentative, having not yet been vetted by the full Subcommittee. Preceding these strategies (particularly payment reform and value-based purchasing) the state should invest/cause investment in a substantially more robust quality measurement infrastructure. See Parking Lot note #2 for more details on desired characteristics of that infrastructure.

#### *Overall objectives*

- The Committee had some discussion of overall objectives for system transformation (slide 10 of presentation), specifically whether or not to set a specific goal in the area of cost containment or affordability. Members agreed to recommend adoption of a goal on affordability including the language on slide 10 concluding that “Health care spending should not increase more rapidly than consumption or personal income.” This could be measured by comparing health care spending to CPI or GDP, but the committee did not wish to recommend a specific numerical target for overall decrease in health care expenditures.
- The Committee asked staff to revise the statement of the equity goal to parallel the committee's principles for a payment system, which are focused on elimination of disparities.

Issues that need further discussion (parking lot)

1. Risk adjustment, for both social and medical factors
2. Need for state investment in a robust quality measurement infrastructure, one that is:
  - Intentional about long versus short term priorities
  - Neutrally available to all and fair/trusted
  - Cost effective for all parties (central administration & data collection/submission)
  - Multi-purposed, including different approaches to:
    - Support learning among stakeholders regarding opportunities, relative benchmark position, business cases for reformed payment approaches
    - Analysis capability for execution of payment strategies (particularly issues of assigning accountability and risk adjustment)
    - Transparency and public use purposes for payment and consumer choice
    - Track potential adverse consequences for redesigned incentives and delivery systems
3. Need for ongoing evaluation to capture ROI
4. Dissemination / PR strategy for rolling out Committee's reform strategies
5. More in-depth, technical review (not a political process) to really identify areas of defects in the system with best potential ROI and, subsequently, most effective strategy for tackling those areas
6. Contracting and payment issues in context of P4P, primary care homes, etc. Levels from OHA – Plans – Medical Groups – Providers.
7. Flesh out the patient engagement material (#3) – needs to be a foundational piece.

Next steps

The group agreed to cancel the Subcommittee meetings scheduled for October 14<sup>th</sup>, since that date was only two days after the Committee's presentation of draft recommendations to the Board. Instead, staff will send around a brief summary of the Board's feedback on October 12 and will do a meeting wizard to find a reasonable time for a full Committee meeting sometime between October 12<sup>th</sup> and November 16, when final recommendations must be presented to the Board. Staff will also distribute the material to be presented to the Board to all Committee members.

Denise Honzel adjourned the meeting at 4:30pm.