Payment Reform Subcommittee of the Health Incentives & Outcomes Committee
Meeting Summary - DRAFT

April 29, 2010
12:30 – 2:30 p.m.

Subcommittee Members in Attendance
Bart McMullan, MD, Chair, Payment Reform Subcommittee
Denise Honzel, Co-Chair, Incentives and Outcomes Committee
Chris DeMars, MPH
David Dorr, MD, MS (phone)
Stephanie Dreyfuss
Megan Haase, FNP (phone)
Steve Jasperson
David Schlactus (phone)
David Labby, MD
Robert Marsalli (phone)
William Murray
Morgan O'Toole
Jim Russel
Sujata Sanghvi
Rick Wopat, MD

Subcommittee Members Not In Attendance
William Olson

Staff in Attendance
Jeanene Smith
Lynn-Marie Crider
Gretchen Morley
Rob Stenger (phone)

Public Comment
Members of the general public who were present did not offer comment.

Meeting Summary (**Committee actions or decisions in bold**)

Dr McMullan convened the meeting at 12:35.

Group Introductions

Jeanene Smith (OHPR) provided a brief overview of the scope of work and timeline of the subcommittee and interactions with the Quality and Efficiency (Q&E) Subcommittee and the full Incentives and Outcomes Committee. Key points included:

- Goal of closely linking the work of the Q&E and Payment Reform (PR) subcommittees
- Key deliverables of the PR committee will include principles and detailed strategies for achieving payment reform over the short and long term
- Monthly meetings of both subcommittees starting in April 2010 with full committee meetings every 3 months
- Proposals for payment reform should support the overall goals of the triple aim
- Short and long term payment reform strategies developed by the committee should include specific attention to implementation… not just abstract concepts and proposals
- The Health Policy Board has asked all committees to give special attention to:
    - Opportunities and barriers created by federal health reform
    - Opportunities to address health disparities and health equity

Members of the committee discussed a number of questions to clarify the scope of work of the committee:

- *Should the PR subcommittee consider both how the state or other payers pay health plans or how health plans pay providers or both?* - Probably both, but the PR subcommittee will focus more on provider payment. Other committees, such as the public purchasers committee will focus more explicitly on contracting with health plans.
- *What providers/services are within the scope of the committee's work (e.g. primary care? Hospitals? DME? Drugs? Tests?) Are there particular priorities?* – All of these areas are within the scope of the PR subcommittee. The committee will need to determine where to prioritize and focus its work based on a set of principles and the opportunities and barriers in the external environment.
- *Should the committee consider other drivers of health care costs aside from the method of payment (e.g. patient incentives/behavior and medical liability)?* – Other cost drivers are clearly a concern in achieving the triple aim. Other committees, such as the Medical Liability Task Force and the Health Services Commission may more explicitly address the issues of liability reform and benefit designs that create incentives for patients to improve their health. The PR subcommittee should work collaboratively with these other groups as it develops its recommendations.

Jeanene Smith and Rob Stenger (OHPR) provided an overview of payment reform efforts in Minnesota and Massachusetts as two examples of leading state approaches (see PowerPoint slides included in the 4/29 meeting materials).

Bart McMullan and Jeanene Smith led a discussion about payment reform principles, using the "Payment Reform Themes" and sample principles in Appendix A of the Payment Reform Report as the basis for the discussion (see 4/29 meeting materials). Key points in the discussion included the following:

- Principles should guide how to construct payment models that support the triple aim goals.
- Payment reform needs to create accountability for providers to deliver care that moves towards the triple aim goals.
- Payment mechanisms need to be flexible over time and encourage continuous innovation, improvement and transformation in the health care system.
- A "one size fits all" approach to payment reform is not likely to be successful – there needs to be some flexibility and adaptability to the needs, capabilities and goals of local delivery systems and communities while recognizing that there will be common overarching goals across the entire system.
- Simplicity and reducing the administrative burden should be a key priority.
- Health equity is important as a principle for payment reform.
- Payment reform proposals need to be scalable to all provider environments and should encourage progress, but not force systems that have achieved a greater degree of integration to "go backwards."
- Stakeholder engagement – payment reform is likely to create disruptions in the current healthcare system resulting in relative "winners and losers." All stakeholders must remain engaged in a productive way for reform to be implemented.
- Market forces – payment reform must address issues such as the market power of "monopoly" providers and lack of transparency on prices that keep health care from functioning as a market and contribute to rising costs.
- Value – buyers of health care (both individuals and organizations) really care about the value of services, but current payments reward the volume of services.
- Payment reform should support common health information technology platforms (opportunity to work with the Health Information Technology Oversight Council – HITOC).
- Limited resources – payment reform proposals should be developed from the premise that resources to buy health care are limited, the current trajectory of cost growth is unsustainable and we cannot afford to add new resources to the overall system.
- Payment reform should be considered from the needs/perspective of the consumer of health care.
- Payment reform should encourage appropriate utilization – only emergencies in the ER, only unavoidable problems in the hospital.

Following the discussion, the subcommittee recommended that staff develop five guiding principles for the subcommittee to review at its next meeting:

- **Accountable – for the triple aim**
- **Transparent – clear incentives**
- **Simple – eliminates waste and prevents abuse**
- **Equitable – fair treatment of individuals and providers**
- **Transformative – serves as an adaptable driver for system change**

Jeanene Smith (OHPR) asked the subcommittee about specific educational topics that would help the subcommittee set priorities and accomplish its work. Subcommittee members expressed a desire to learn more about the following topics:

- Payment reform opportunities created by Federal health care reform
- Specific data on regional variations in care delivery, prices and cost shifting in Oregon

Dr McMullan adjourned the meeting at 2:25.