Minutes

LINE ZERO TASK FORCE
Meridian Park Hospital
Health Education Center, Room 107
Tualatin, OR
Thursday, August 24, 2006

Members Present: Daniel Mangum DO, Chair; Somnath Saha MD, Kevin Olson MD; Susan McGough; Kathryn Weit

Staff Present: Darren Coffman; Dorothy Allen.

***Also Attending**:* Jeanene Smith MD, Office of Health Policy & Research; Tina Kitchen MD, DHS; Monica Herrera and Walter Shaffer MD, Office of Medical Assistance Programs; Scott Gallant, Oregon Medical Association; Lisa Krois, Public Employee's Benefit Board; Rick Wopat MD, Samaritan Health Systems (via phone).

Note: Adjourned 9:10 a.m. The next Line Zero Task Force meeting is scheduled for Thursday, September 14, 2006 12:00 p.m. in Room 218, Clackamas Community College, Wilsonville Training Center, 29353 Town Center Loop East, Wilsonville, Oregon.

TOPIC	NEXT STEP
LOOK AT LINE ZERO RESTRICTIONS FOR OHP STANDARD, OHP PLUS or BOTH? Currently there are areas of restrictions on benefits involving line zero that affect only OHP Standard (e.g. non-emergency transportation is not covered) so similar decisions can presumably be made. Ideally many decisions from this task force will apply across the board to both groups.	1. Efforts will be directed at line zero services that may produce cost savings and lead to the most appropriate care for both groups. 2. Consider areas of possible restrictions for OHP standard alone.

TOPIC	NEXT STEP
ELIMINATE LINE ZERO? Rick Wopat suggested that line zero could be eliminated by placing all codes on the Prioritized List of Health Services. The reason behind this is the concern that some care is being done for problems below the funding line (e.g. someone with chronic back pain getting an MRI showing only osteoarthritis of the spine…both areas are non-funded conditions but both currently would be covered) or inappropriate codes are being used (e.g. an appendicitis code used for the same MRI of the spine). This process would be an enormous task of questionable value and could not be completed in a timely fashion. This would be difficult for "signs and symptoms" codes as many would need to be placed on both funded and non-funded lines. This approach may create more costs through the initial denial of payment and subsequent re-billing for services using a "funded" code.	1. Gather more details on services provided and corresponding diagnostic codes. Specifically what are the costs of services for signs and symptom codes? What codes below the current funding line are being used for imaging or other studies? 2. Gradually look at this area with the potential goal of elimination of line zero, if possible.
CONCENTRATE ON HIGH COST AREAS FIRST? Imaging studies are the greatest cost ($183 million), just exceeding ED costs ($180 million). Imaging studies could be restricted by a limited number per year or a budgeted amount per year as some states have instituted. It would be the simplest to implement and budget but this approach is the most arbitrary and lacks any evidence nor really reason or logic.	Strongly recommend the use of a imaging company for prior authorizations for certain imaging studies.

TOPIC	NEXT STEP
Several years ago the Line Zero Task Force suggested that the state contract with an imaging company to review/prior authorize some of these studies (CT scans, MRI's, PET). This never was pursued, but this kind of service is now more accepted by physicians and used by many insurance groups, and almost certainly can lower costs while utilizing an evidence-based algorithm.	
ESTABLISH CAPS ON SERVICES? Many states are currently placing a limit on services. There seemed to be a general reluctance by this task force to pursue a strict cap across the board, regardless of the circumstances. A cap would lack evidenced-based conclusions on which the HSC bases its decisions. There could be two-levels of caps. A very restricted basic service (OHP Standard - Restricted) and the current open level (OHP Standard - Open). Individuals could qualify for open coverage based on a diagnosis or line item (cancer lines, diabetes, HIV, etc) or based on a simplified exclusion process such as a physician-ordered exclusion because of severity of their (chronic) illness and need for more frequent or intense services.	Pending further discussion at the next meeting to include the following questions: 1. Is it worthwhile to determine and set a cap on services in order to try and contain costs when there is no data to clearly show excess or inappropriate care is being done? 2. Would caps have unintentional consequences (e.g. someone with asthma has had their maximum number of visits for the year but had an asthma flare needing treatment so they go to the ED instead of the office)? 3. Is any discussion and decision for caps really appropriate for the HSC, or should this be made by others like those deciding on co-pays or other financial incentives?

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Members Present: Daniel Mangum DO, Chair; Somnath Saha MD; Kevin Olson MD; Susan McGough; Kathryn Weit.

Staff Present: Darren Coffman; Dorothy Allen.

***Also Attending**:* Tina Kitchen MD, DHS; Isabel Bickle and Monica Herrera, Office of Medical Assistance Programs; Lisa Krois, Public Employee's Benefit Board; Laura Sisulak, OPCA; Dayna Steringer, Providence Health Systems.

Note: Adjourned 1:56 p.m. Potential future meeting at the discretion of the Chair, dependent on future information.

TOPIC	NEXT STEP
Review of August 24, 2006 meeting highlights. Discussion of the topics: • Look at line zero restrictions for OHP Standard, OHP Plus or both? • Eliminate line zero? • Concentrate on high cost areas first? • Establish caps on services? • Recommend use of an imaging company for prior authorizations for certain studies.	Affirmed previous meeting's recommendations.
Is a medical home feasible for Medicaid patients? Patient's obstacles to care include: cost and access. What is the best team composition to provide care? Physician obstacles: Treatment issues are great while reimbursement is low.	1) Staff were asked to gather data showing the number of physicians who: • accept Medicaid patients. • accept new Medicaid patients. • do not accept any Medicaid patients. 2) Optimally, increase reimburse rates to 85% of private insurance rates. Would this reduce ED visits? Possible pilot project?

TOPIC	NEXT STEP
Reduce Emergency Department Visits Evaluate if a medical home reduces ED visits. A study by Bob Lowe shows that those who have access to a safety-net or primary care provider (PCP) probably do visit the ED less. Tina Kitchen reports that OMAP will be paying the ED for a "triage fee" to determine the most appropriate care facility for those seeking treatment in the ED.	1) Provide incentives for PCPs to increase their Medicaid patient load. 2) Evaluate OMAP's new triage program to see if there are financial savings.
Review Line Zero Data Of services that would fall below the line, ED visits and Radiology are the top two most expensive Line Zero costs, totaling nearly $84M. Line Zero data showed $19M for "Complications mainly related to pregnancy." Of that amount, $5M was for ICD-9-CM Code 648.93 Other Current Maternal Conditions Classifiable Elsewhere, Anti-partum, the highest costs going for ED visits. Those codes are paired on the list, and should be charged to that line. It appears that because the visits are in the ED, these costs are showing up on Line Zero. Another example is $94M charges under Line Zero for code 995.59, Childhood Abuse & Neglect. The service being provided is "targeted case management' and should not be a Line Zero cost, and perhaps should not be an OHP charge at all.	

TOPIC	NEXT STEP
Caps on Services *Is it the purview of the Health Services Commission to place a cap on services?* The HSC makes decisions based on evidence-based research. Arbitrary caps are not based on science. Good practice recommendations for less costly care, such as Physician Assistants and Nurse Practitioners. Caps would provide a simple way to save money and could possibly allow coverage to a larger population who have no coverage now. There is legislation that prevents caps on prescription medication.	<u>Data requests:</u> 1) Staff will contact states who use caps to find out the impact those limitations have on total costs, ED visits etc. 2) Staff will gather information on individual patient utilization of services, including prescription medication usage. Potential future meeting at the discretion of the Chair, dependent on future information.