MINUTES
PRIORITIZATION PRINCIPLES WORKGROUP
August 11, 2005

Members Present: Eric Walsh, MD, Chair; Rick Wopat, MD; Dan Williams; Kathryn Weit; Somnath Saha, MD, MPH; Michael Garland, DScRel; John McConnell, PhD (by phone); Susan McGough (by phone); Mike Bonetto, MPH (by phone). Members participating by phone joined at 9:00 a.m.

***Members Absent*:** None

Staff Present: Darren Coffman; Alison Little, MD, MPH; Bruce Goldberg, MD; Dorothy Allen.

Also Attending: Sharron Kelly, Governor's Council Alcohol and Drug Abuse; Steven Dufrin, Capitol Dental Care; Nicola Pinson, Oregon Primary Care Association; Betsy Earls, Kaiser; Mark Branlund, Governor's Council Alcohol and Drug Abuse ; Tina Kitchen, DHS SPO; Kevin Earls, Oregon Association of Hospitals & Health Systems; Barry Anderson, PSU

I. Call to Order

The first meeting of the Prioritization Principles Workgroup was called to order at 8:40 a.m. in Room 103 of the Oregon State Library, 255 Capitol Street NE, Salem, OR. Members of the Committee and staff introduced themselves around the table.

II. Purpose of Workgroup

Dr. Walsh shared his history and his attraction to the Oregon Health Plan when he initially moved to Oregon in the early 1990s, followed by his disappointed as the health plan membership and benefits declined. He explained that the Commission has attempted to address these issues by "squeezing the List" and relying on evidence-based medicine; however, this has had minimal effect compared to the effects of the recession and declining tax revenues. The Commission heard a presentation from Dr. Wopat at their last meeting detailing his ideas for increasing the public value of the health plan, and elected to establish this workgroup to explore the issues and obtain more information.

III. Review of Rick Wopat's Proposal

Dr. Wopat gave a brief summary of his proposal, specifically, how to provide services to those who are not categorically eligible in a way that will improve their health and reduce avoidable costs. There is good evidence that some health services reduce long-

term disease and hence costs (prevention and treatment of chronic diseases). His proposal would reduce acute care services and increase coverage for prevention and chronic disease management. Some services are known to save health care costs, yet those services are not provided universally. This proposal would attempt to change that. He envisions a reorganization of the lines on the List, and then two different funding lines. He recommends maintaining only one List, as the priorities should be the same for both Standard and Plus populations, and administratively, two Lists would be much more difficult. Dr. Goldberg pointed out that the prioritization of the top 300 lines of the list have not really been examined since their creation, and now is a good opportunity to do so. Mr. Williams asked what the givens (constraints) are, and Dr. Goldberg responded that federal policy limits OHP Plus, while state statute limits both OHP Standard and OHP Plus. Dr. Wopat clarified that he does not intend to change federal policy. Dr. Walsh felt that simplicity was a given, which likely means only one list, as is the need for buy-in by constituencies. Dr. Garland believes that the guiding values of the Oregon Health Plan, as derived from community meetings, must continue to guide any new benefit design. Dr. Kitchen pointed out that whatever is developed will ultimately have to be approved by CMS. Dr. Goldberg clarified that the Health Services Commission always has the ability to re-prioritize items on the List, but that funding is determined by the legislative body. Dr. Wopat noted that the Commission could reconsider the structure of the List, including the need for lines rather than larger groups of categories.

Ms. McGough stated that she has briefly reviewed how other states have handled budgetary constraints on Medicaid, and several are pursuing a hybridization of traditional Medicaid with the concept of personal health savings accounts. She suggests adding financial alignment and focusing on chronic disease management to promote cost containment, thereby increasing the number of people covered. Dr. McConnell expressed concern with this approach, noting his research findings that, in response to the institution of cost-sharing in OHP through co-pays and premiums, there has been a decrease in the utilization of chronic disease services and an increase in inpatient utilization. He feels that cost-sharing is effective in the commercial population, but not for Medicaid. He also doesn't feel that this would be effective cost-control, since the bulk of the expense is incurred by acutely ill patients in an inpatient setting, who would empty their account immediately. He is also concerned about offering incentives to a population who has no income at all, which may increase enrollment solely for that reason.

Ms. McGough expressed concern about obtaining buy-in from the population and from hospitals in a system which only covers primary care. Dr. Walsh stated that, while he concurs with the principles of cost-containment, he feels that details such as health savings accounts are more of an issue of implementation, and within legislative purview rather than this workgroup. He also expressed concern about health savings accounts, doubting that return of dollars to recipients was the best use of scarce state dollars. He feels there are some good examples of population-based preventive care, such as the decline in stroke and heart attack rate with the initiation of aggressive treatment of hypertension and cholesterol. He also wonders whether expanding coverage to an

additional 70 to 80 thousand people for prevention and chronic disease management will ultimately be cost neutral or cost-saving for the hospitals, despite a decrease in coverage for acute care. He encouraged the workgroup to limit emphasis on implementation.

Mr. Bonetto asked whether or not input from the hospitals had been obtained, and thought they would be the biggest obstacle to a plan to divert dollars from acute care to primary and preventive care, given that currently they and the health plans fund the standard population entirely. He is also not convinced that this small change, pertaining only to a small segment of the Medicaid population, will result in any significant cost savings, which would require involvement of a much larger portion of the state health care dollars. He also questioned what the outcomes and measurables would be. Dr. Goldberg responded that the concept is too ill-defined at this time to present it to any stakeholder group. Dr. Wopat responded that hospitals are not unified in their opinions. Kevin Earls disagreed, noting the historical importance that the State has placed on funding the actual cost of care for Medicaid. He feels that considering changing a benefit package that is entirely funded by private entities (hospitals and health plans) without their input is “a little bit cavalier.” Dr. Walsh feels it is premature to have such concerns, and that it is impossible to know what the financial implications of adding coverage for 80,000 people for chronic disease but eliminating some services for 20,000 people will be without doing the actuarial work first. Ms. McGough wondered if the State could guarantee the same level of reimbursement if a pilot program were undertaken. Drs. Walsh and Wopat encouraged defining what the program might look like before considering this level of implementation.

Dr. Walsh reminded the group that the Health Services Commission represents the patients on the Oregon Health Plan and no other stakeholder. He encouraged development of economic models, which can then be critiqued, but that a model is required first. Ms. McGough expressed concern that a model might be developed which had no hope of succeeding if stakeholders were not included at the beginning. Dr. Garland suggested filtering or re-sorting the list into the 17 buckets, re-prioritizing the list emphasizing prevention and chronic disease and seeing what it looks like. He believes this is a worthwhile task, and should be undertaken before dealing with implementation concerns. Dr. Saha discussed the possibility of changing the list into a list of 17 categories, with focus on the principles of prevention; however, doing this would result in a loss of specificity of the list, with some less important things being covered and more important ones not being so, and may lose the ability to consider cost-effectiveness. Dr. Wopat suggested that the bucket concept could be modified or expanded to include such things as effectiveness of treatment. Mr. Williams reminded the group that what we have now is not very good, and is not sustainable, hence new ideas need to be explored.

Audience member Dr. Barry Anderson suggested that another methodology would be to define 17 categories of benefits, then divide these by the actual associated costs to get cost-benefit ratios. Dr. Wopat pointed out that the 17 categories are 15 years old and

likely need to be updated. Dr. Walsh summarized his impressions of the meeting as follows:

- Look at reprioritizing the Prioritized List, using the 17 categories as a filter for a starting place
- Have only one List
- Potentially have two different funding lines
- Goal is to increase the number of insured lives on OHP Standard
- Re-examine the emphasis on individual health versus population health
- Keep realism in the process

Each person provided their own perspective, as follows:

Mr. Williams agreed in general, however felt Dr. Walsh's summary was too specific, and that the problem was not well enough defined yet.

Dr. Goldberg concurred, encouraging a broader review of the issues.

Dr. Saha agreed with Dr. Walsh's summary, but encouraged attention to practical issues at the same time as the work on principles is being done.

Dr. Garland agreed that the work group should move forward as stated by Dr. Walsh, but also reminded the group that the Health Services Commission is in charge of the List, and it is within their purview to create a <u>better</u> List.

Dr. McConnell concurred, adding that he encourages inclusion of cost-benefit ratios in the early work of the group.

Ms. McGough encouraged looking at the long-term outcomes while philosophical work proceeds, drawing the analogy between pure and applied science.

Mr. Bonetto agreed that it was important to consider reality during the process, and feels that the current work may not be enough to make significant changes in the health care system. He feels that the current problems of unsustainable cost increases will persist.

Mr. Coffman stated that staff is available, and asked for a little more direction. Dr. Walsh stated that minutes would be circulated for comments and edits.

Dr. Wopat referenced Senate Bill 27 and the values obtained from public meetings, and concluded that the main issue to be dealt with is the difference between preventing death and value to the entire population. One of the original criticisms of the List was that too large of a value was placed on an individual life saved; he believes the importance should be shifted, such that preventing a disease is more important than treating a disease.

Senator Monnes-Anderson from the audience stated her goal as a lawmaker is to get the most bang for the healthcare buck, hence she favors covering more Oregonians. She feels it important to know the utilization, the costs and the cost-effectiveness of each line.

Ms. Weit encouraged open conversations without interference from special interests. She encouraged specific examples and making the discussion as concrete as possible.

VI. Next Steps

Minutes will be circulated for comment, then Drs. Walsh, Little and Goldberg and Mr. Coffman will consider the utility of another meeting of this group before the next meeting of the Health Services Commission on September 22. Mr. Coffman noted that today's meeting lacked a thorough discussion of values. He pointed out that in the 2004 Health Values Survey, preventive and primary care are the top benefit priorities. Dr. Saha was concerned about the lack of specialty representation on the workgroup and the Health Services Commission.

VII. Adjournment

The meeting adjourned at 10:15 a.m.

MINUTES
PRIORITIZATION PRINCIPLES WORKGROUP
September 12, 2005

Members Present: Eric Walsh, MD, Chair; Rick Wopat, MD; Dan Williams; Kathryn Weit; Somnath Saha, MD, MPH (arrived at 3:25 p.m.); John McConnell, PhD (arrived at 3:27 p.m.); Mike Bnetto, MPH (by phone).

***Members Absent*:** Susan McGough, Michael Garland, DScRel.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Bruce Goldberg, MD; Dorothy Allen.

Also Attending: Steven Dufrin, Capitol Dental Care; Betsy Earls, Kaiser; Jane Myers, Oregon Dental Association; Tim Boehm, Capitol Dental; Tom Turek, MD, OMAP; Jane Baumgarten, League of Women Voters; Helen Trotter, United Seniors of Oregon; Nicola Pinson, Oregon Primary Care Association

I. Call to Order

Dr. Eric Walsh, Chair, called the second meeting of the Prioritization Principles Workgroup to order at 3:07 pm in Hearing Room E of the Oregon State Capitol, 900 Court Street NE, Salem, Oregon. Darren Coffman called roll.

II. Outline of Meeting Strategy

Dr. Walsh gave an overview of the committee and asked that the workgroup stay focused on discussing this group's recommendation to the Health Services Commission. He then asked for comments.

Dr. Rick Wopat stated that he had recently given his prevention-focused proposal to the Oregon Association of Hospitals and is scheduled to meet with their board in October to continue his discussion of the concept with them.

Additionally, Dr. Wopat presented the concept to the Medical Directors of the fully capitated health plans and dental plans that morning, to a generally positive reception.

Dr. Wopat said that he garnered from the first meeting the idea that additional work should be done with stakeholders and has started that process.

Mr. Dan Williams asked if the hospital group expressed any unease about the process or the proposed changes. Dr. Wopat replied that there may be some unease about the process. Further, when the hospital group agreed to the provider tax, the assumption was that the money would help to fund the program and allow the hospitals to continue to receive payment for some clients on OHP Standard. It may take some convincing for them to see it is better to invest that money in non-hospital services.

III. Review of Original 17 Categories of Care

Mr. Darren Coffman began his discussion of this topic by stating that during the original utilization of the 17 Categories of Care, the Commission opted to hand-move approximately 41% of the line items up or down, after the category sorting took place. Using the current methodology, nearly 75% of the line items were hand-moved.

The first nine of the seventeen categories were deemed to be essential services and should be part of any benefit package: Acute fatal (with return to previous health state), maternity care, acute fatal (without return to previous health state), preventative care for children, chronic fatal, reproductive services, comfort care, preventive dental care, proven effective preventive care for adults.

The next group is considered very important services: acute nonfatal (with return to previous health state), chronic nonfatal (one time treatment), acute nonfatal (without return to previous health state) and chronic nonfatal (repetitive treatment). These categories are the “gray area” of the prioritized list and coverage is dependant on funding.

The last four categories are considered services valuable to certain individuals but not society as a whole and have never been funded: self-limited conditions, infertility services, less effective preventative care for adults, fatal or nonfatal (treatment causes minimal or no improvement in quality of life).

Dr. Wopat mentioned that one of the principles he recalled is that the Commission would never rank a screening or prevention service below the treatment of the condition it was meant to prevent, and wonders why maternity care is ranked above reproductive services.

Mr. Coffman stated that even though it appears that way on the category list, looking at the Prioritized List of Health Services shows that birth control appears higher on the list than pregnancy.

IV. Overview of OHP Principles

Mr. Coffman reviewed for the workgroup the document "OHP Principles and Policy Objectives." While researching OHP Principles, Mr. Coffman said he did not find anything in the original values to contradict the direction of the prevention focused model. Those items that he found supportive of the concept included:

- A workgroup convened in 1987 by Governor Goldschmidt, prior to the OHP legislation, drafted a set of core principles that informed the legislation, including "there must be a process to define a "basic" level of care."
- The 1987 preamble of the statutory language creating the Insurance Pool Governing Board states, "it is the intent of the Legislative Assembly...to increase access to health insurance by developing a program employing preventative and primary care and then to minimize the medical care cost shifts caused by the providing of uncompensated care by hospitals."
- 1989's SB 27 directs the HSC to "report…a list of health services ranked by priority from the most important to the least important, representing the comparative benefits of each service…"
- The only two health care values mentioned at all 47 of the community meetings conducted by Oregon Health Decisions in 1990 were "prevention" and "quality of life," the latter of which is a primary benefit in the management of chronic diseases being discussed.
- The public outreach effort called Making Health Policy 2000 resulted in two related findings included "…the need for new strategies for sustaining progress toward covering more Oregonians" and "all Oregonians should have access to a basic package of health care benefits…with recognition of limits on financial resources available."
- The Task Force on Basic Benefit Plans, convened in 2000, concluded a basic benefit plan for uninsured low-income Oregonian adults should stress access promotion over asset protection.
- The Health Values Survey 2004 found public support that preventive and primary care should be guaranteed even when resources are constrained.

Mr. Coffman also outlined the process the HSC used involving the original methodology, including the use of public values in ranking the seventeen categories of care. He noted that aside from the designation of the top nine categories being essential, there was no decision on what would constitute a basic benefit package. Dr. Wopat pointed out that the legislature was charged with determining what benefits would be provided, so the HSC consciously chose to refrain from making recommendations in terms of funding levels on the list.

Dr. Walsh stated that he would like to see the prevention focused model analyzed though the original 17 categories from the prospective of cost, access and values.

Ms. Kathyn Weit asked about the role of Medicaid and its mandate for health and safety. The members discussed the difference between those who are categorically eligible and receive OHP Plus, which is the fullest benefit package, and those who, without the Oregon Health Plan, would have no coverage. Dr. Goldberg believes that the benefit changes being discussed would not be out of line with what CMS has already approved for other states.

Dr. Wopat spoke about the three factors the HSC currently uses to prioritize health services: Importance of treating the condition; effectiveness of the treatment in preventing death; and relative cost. The prevention model requires a leap to different thinking where prevention is more important than acute fatal conditions.

Others agreed that it is a core issue. Is treating one acute fatal condition at $150,000 more important than providing prenatal care or birth control to 50 women? It is not a question of what people will get, but rather what the state will pay for.

Dr. Bruce Goldberg shared that he sees this as a values issue, ranking services based on the value of prevention, given the limited funding available, doing the best for the most.

Mr. Williams stated that the positive thing about OHP is that it does the exact opposite with Medicaid dollars than what the federal government does. The federal government gives "a lot to a few" while OHP gives a little bit to more people and seems to "speak to prevention by definition."

Mr. Mike Bonetto shared that he supports pilot programs of the prevention focused model, keeping in mind that this has to be in concert with a bigger picture of reform.

Dr. Somnath Saha mentioned that it is said "an ounce of prevention is worth a pound a cure," but preventative services are not necessarily cost-saving or even cost-neutral. Many preventive services are in fact very expensive. Screening may appear to help thousands of people, but it is really only helping the one or two people who have the condition. The thought is that you are buying wellness and health maintenance.

V. Discussion of a Potential New Set of Categories to Reflect Desired Framework for a Revised Prioritized List

Dr. Walsh shared a draft document with the 17 categories re-ordered with a prevention focus for the workgroup to review (see Attachment A). He asked the workgroup to view this list as a starting point.

VI. Next Steps

Dr. Walsh asked for a statement from the group with their formal recommendation to the Health Services Commission. After a few attempts at formulating one, Mr. Williams proposed the following motion.

MOTION: Recommend to the HSC that they undertake a project to re-examine the priorities as expressed by the Prioritized List* that could be designed to be of benefit to a greater number of people than they are right now that become a project of the HSC. MOTION CARRIES: 7-0.

VII. Adjournment

The meeting adjourned at 4:30 p.m.

At Dr. Walsh's suggestion, after the conclusion of the meeting and upon reviewing the tape, Mr. Coffman formulated the following statement to fully capture the Prioritization Principles Workgroup's proposed recommendation to the Health Services Commission based on their discussions throughout the meeting:

The Prioritization Principles Workgroups recommends that the Health Services Commission re-examine the Prioritized List to see if priorities that emphasize prevention and chronic disease management would result in a greater benefit to the population being served by OHP, given the allocations currently allotted by the legislature.

The workgroup has communicated by e-mail that this is an accurate encapsulation of the day's discussions and it will be taken to the Commission's September 22, 2005 meeting as a recommendation.