

OREGON HEALTH FUND BOARD – Delivery Systems Committee

March 31, 2008
1:00 – 5:00 pm

CCC - Wilsonville Training Center
29353 Town Center Loop East
Wilsonville, Oregon

MEMBERS PRESENT: Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Tina Castanares, MD
Bill Humbert
Carolyn Kohn (by phone)
Diane Lovell
Stefan Ostrach
Ken Provencher (by phone)
Mike Shirtcliff, DMD
Rick Wopat, MD
Charlie Tragesser
Mitch Anderson
Dale Johnson
Bart McMullan, MD
Doug Walta, MD, Vice-Chair
Vickie Gates
Vanetta Abdellatif

MEMBERS ABSENT: David Ford
Lillian Shirley, RN

STAFF PRESENT: Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Ilana Weinbaum, Policy Analyst
Zarie Haverkate, Communications Coordinator

ALSO ATTENDING: Barney Speight, Director, Oregon Health Fund Board (OHFB)

- Call to Order/Review of 03/13/08 Meeting Minutes
- Review of Cost Containment Strawperson Recommendations
- Invited Testimony – Oregon Association of Hospitals and Health Systems
- Payment Reform: Minnesota's Payment Reform Proposal
- Payment Reform Discussion
- Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Chair Stenson I. **Call to Order/Approval of 03/13/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order at 1:10 pm. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Staff overviewed agenda.

II. Review of Cost Containment Strawperson Recommendations: Improve Quality and Efficiency and Increase Accountability (See Exhibit Materials 2 and 3)

Jeanene Smith presented updated information on the Framework Diagram from last meeting's discussion which included incorporation of Accountable Care Organizations (ACOs) which are referred to as Accountable Care Districts (ACDs) (**see Exhibit Materials 2**).

Dr. Smith reported that she, Maribeth Healey and Dick Stenson highlighted preliminary information to OHFB.

Definition and recommendations surrounding Accountable Care Districts are discussed.

- Recommendation 1 (page 1) suggestions/discussion included:
 - Expanding definition of ACDs.
 - Clarification that a financial relationship is not required between physicians and hospitals.
 - Utilizing data as a competitive tool in the marketplace.
 - Include local health authorities and mental health authorities as part of ACDs which may lead to county participation in discussion surrounding ACDs.
 - Discussion on how aggregating quality data will improve system.
 - Suggestion to accept the ACD language with broader definitions.
- Recommendation 2
 - Discussion to remove/change last sentence that refers to preference for funding pilot projects in communities that have already exhibited community collaboration. Suggested that instead should develop method to encourage participation from areas that have not benefited from organized community collaboration.
 - Who will be the facilitator/project manager in each district?
 - Different communities may have different players at the table.
 - What would the funding be covering? Recommendation 1 would be data aggregation alone and recommendation 2, would include funding for regional planning. Discussed implications on budget.
 - Recommendation for evaluating potential applicants for feasibility. The importance of early success is stated.
 - Differences between ACD models in metropolitan and rural areas.
 - Should allow other communities, especially in metropolitan areas where a pilot is being funded, to participate voluntarily.
 - Question posed: Is Committee ready to make ACDs the centerpiece of the cost containment recommendations?
 - Most members still have a lot of questions.
 - Debate on whether pilots can be accomplished through community collaboratives alone and the funding that would be required.
 - ACDs are described as economic zones.
 - Dialogue on using data to change behavior.
 - Assumption made that with data and infrastructure and with some collaboration, issues can be identified and changes affected.
 - Discussion of political implications.

- Providers will look at data more than consumers and it will shine light on variation.
- Public transparency, economic stimulus to change and public/community involvement discussed as three necessary components.

Comparative Effectiveness Analysis and Medical Technology Assessments
(see page 3)

- Recommendation 1:
 - Concern that recommendation would duplicate other work already in existence. Discussion of other efforts.
 - Transparency and neutrality as a reason for supporting involvement by Human Resource Commission (HRC).
 - Need to highlight collaboration.
- Recommendation 2:
 - May require most political involvement of the recommendations due to claims by vendors/manufacturers of their products' value.
 - Make a stronger statement regarding requiring evidence of value of new technologies and treatments.
 - Discussion and support for last sentence regarding collaboration.
- Recommendation 3
 - Similarities to Minnesota model explained, noting it relates to recommendation 1.
 - Discussion of existing efforts to create clinical guidelines. Many different sets have been created.
 - Pertains to inpatient and outpatient treatment.
 - Expand the language beyond clinical guidelines, including social support, mental illness and other chronic conditions.
 - Members were encouraged to contact staff regarding any suggestions and specific language changes.

Administrative Simplification discussed (see page 3).

- Recommendation 1
 - Bullet 3 - In citing electronic exchange in the recommendation, it was noted that the Governor has directed the formation of the Health Information Infrastructure Advisory Council (HIIAC) to research implementing electronic health records. Staff related that the simplification recommendation is in relation to billing.
 - Need for a periodic evaluation process.
 - Suggestion to separate recommendations about administrative costs from administration streamlining suggested.
 - Will transparency be required for Medicaid administrative costs?
 - Define object of administrative simplification.

Reduce Pharmaceutical Spending (see pages 3-4).

- Recommendation 1
 - Suggestion there should be one standard for all not only state health programs.
 - Effectiveness of the Oregon Prescription Drug Program (OPDP) is debated.
 - Formularies discussed. Change wording to state that the most cost-effective program should be utilized.

Shared Decision Making (page 4)

- Need to get approval from safety net. Tina Castanares and Vanetta Abdellatif will submit language to staff.

Staff will revise recommendations incorporating member input and return to the Committee.

Kevin Earls

III. Invited Testimony – Oregon Association of Hospitals and Health Systems (See PowerPoint presentation).

Kevin Earls, Vice President, Finance and Health Policy, Oregon Association of Hospitals and Health Systems (OAHHS) returned to provide additional information with focus on issues of cost drivers of the hospital industry, competition in the market place and hospital margins.

- Cost drivers presented included aging population, increase of 8-10%/year of individuals with chronic conditions, innovation and technology, labor costs and effects of workforce shortages, uninsured and the cost shift to payers.
 - As Medicaid and Medicare drop further below actual costs, these costs are shifted directly to rates of commercial purchasers.
- Competition in the marketplace - Ambulatory Surgery Centers (ASCs) in competition with hospitals.
 - Regulatory inequities discussed.
 - Is the increase in ASC's profit driven or service driven? Discussion on the role of ASCs and the effect on costs.
 - Discussion of article from Health Affairs of a study on physician referral patterns to ASC's which shows populations seen by ASCs is different than that of hospitals.
- Hospital margins and growth in uncompensated care related.
 - One-third of Oregon hospitals will have a negative margin in any given year.
 - The need for margins.
 - Hospital margin statistics for 2007 provided.

Discussions/Questions

- Suggestion of more regulation on ASCs is needed to correct regulatory inequities between hospitals and ASCs.
- Discussion of range of margins among Oregon hospitals.
- Do reserves also fluctuate with the margin? Kevin Earls will get the information and provide it to the Committee.
- How does the hospital address the high cost of some procedures?
 - It's a conversation that should involve hospitals and physicians.
 - Decision is usually made by physician.
 - Preferred vendor or preferred device list and an agreed upon community standard is discussed.
- Explanation of margins, including gross margins that include areas unrelated to patient care. Patient-service margin is discussed.
- Suggestions by Kevin Earl for systemic improvement:
 - State as purchaser to pay 100-105% of cost of service.
 - Uniform drug purchasing methodology that every commercial purchaser uses for Medicaid.
 - Do you want to have investor-owned medical facilities segmenting care out of a community hospital?

- Information was shared about the Oregon Healthcare Workforce Institute that was formed by the Association about 2 ½ years ago to address the workforce shortage.
- Discussion on payment reform.
 - Response by Kevin Earls that flat fees will not work.
 - Stated that it is necessary to Change hospitals' perception that they are cost centers and not income-generating centers. Kevin Earls responded that hospitals are efficient and judicious in utilization and discussed existing opportunities to capitalize on relations between doctors and hospitals to affect change. Stated that necessary to get healthcare providers buy-in to these changes.
- Assertion that hospitals are efficient but costly and cost is shifted to payers.
- Early discussion may be the pathway to solutions that include cost containment, transparency, evidenced-based solutions, and explicit decisions about what will be covered.
- More transparency of hospital spending and a commitment by hospital association for full participation in the accountable care districts is needed.
- The effect of anti-trust laws in interfering with the ability to collaborate is discussed.

Barney Speight

IV. Payment Reform: Minnesota's Payment Reform Proposal (See Exhibit Materials 8)

- Prior to providing information on Minnesota's Payment Reform Propose, Barney Speight:
 - Related there is an expectation that State will be a major contributor and coverage could be expanded to 300,000 more Oregonians under Medicaid.
 - there is no State financial commitment to obtain federal matching funds; and
 - there is a fundamental suspicion by public that the current system will continue to generate at a rate of increase that is unsustainable, especially for the public sector.
- In response to Kevin Earls presentation he related:
 - Oligopoly definition of hospitals and industry implications.
 - Suppressed prices of the nineties interpreted as being artificial.
 - To dispel public skepticism, suggested absolute transparency in price increases and single price policy.
- Single price policy from Minnesota's Payment Reform Proposal restated (page 2).
- The need to relate to public on hospital operating margins, earnings before interest, tax and depreciation and reserves.
- Hospitals are not carrying the burden of uncompensated care, but pass it on to payers.
- Need candid conversation on the role of a hospital. Communities vote on new construction/changes in schools/fire departments but have no say in what hospitals do. Should be oligopoly or monopoly.
- Most essential first step is to increase Medicaid payments.

Chair Stenson

V. Payment Reform discussion

- Do you have an example internationally on a fee-for-service transparency model that has worked?

- Barney responded that he did not and many of the international models are not built around fee-for-service.
- Transparency of price does not have to be limited to fee-for-service.
- Further discussion with Committee on transparency and value performance dimension resulting in informed purchasers.
- Value performance dimension related to price may result in informed purchasers.
- Discounting and bundling of services discussed.
- Legality of a single price without a single payer will be researched.
- Chronic underpayment by Medicaid/Medicare discussed. Will increasing Medicaid population through Oregon Health Plan (OHP) drive up costs?
 - Below costs payments vs. charity care related.
 - What mechanism do we put in place that gives the public confidence that costs are being monitored?
- Possibility of a global cap encompassing all pieces is hindered by the many “mini-budgets” that exist and possible use of John McConnell’s Accountable Care District pilot recommendation in this area.
- Discussion on limiting coverage and effects on quality. What are the tradeoffs? Public’s perception of healthcare is through marketing efforts and need information/transparency to make decisions.
- Demographics of Minnesota and Oregon compared.
- Consensus to carry to single-price proposal forward.
- Staff will look at regulations on ASCs and acquire model legislation.
- Three tier model overviewed (**Exhibit Materials 6**). Staff review panel will work on it coupled with price transparency.

Future Meetings and directions were discussed:

- Two more meetings remain, April 17 and April 28. Next meeting will include Quality Institute Workgroup recommendations, fleshing out of public health wellness initiatives, and palliative care.
- Recommendations to be finalized at last meeting. Board seeking recommendations by early May.
- Suggested that palliative care be tied into Tier 2, Care Coordination Payments.
- Staff Review Panel for the payment reform proposal will consist of Vanetta Abdellatif, Bart McMullan, Rick Wopat and Dale Johnson.
- Other members of the committee are urged to email staff to contribute language for recommendations discussed.
- Committee expressed it would welcome the opportunity to interact with other committees on how the recommendations will fit together.

VI. Public Testimony

- No public testimony offered.

Chair Stenson

IX. Adjourn

Chair Stenson adjourned the meeting at 4:45 p.m.

Next meeting is April 17, 2008.

Submitted By: Paula Hird

Reviewed By: Ilana Weinbaum

EXHIBIT SUMMARY

1. Minutes from 03/13/08.
2. Diagram of Framework for Delivery System Reform - Revised 03/18/08
3. Cost containment strawperson
4. Comparative Effectiveness Summary
5. Minnesota Administrative Simplification Act
6. Payment Reform Proposal
7. Payment Reform and Provider Reimbursement
8. Minnesota Payment Reform

DRAFT