



Guiding Principles for Benefit Design and Coverage Decisions

**Prepared for
Department of Vermont Health Access**

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EXECUTIVE SUMMARY

OVERVIEW

Vermont faces budget constraints in Medicaid that restrict its ability to provide open-ended access to medical services. As a result, the State must ensure that the services it does provide are the most effective at improving the health of beneficiaries. To do so, the Department of Vermont Health Access (DVHA) must be able to determine the clinical value of health services using a well designed appraisal framework based upon credible research methods. The process for applying this framework to policy development must be driven by a set of organizing principles based on the values of Vermonters, and applied in a logical and transparent process. The DVHA contracted with the Center for Evidence-based Policy (CEbP) at Oregon Health & Science University to support the process of developing and applying these principles.

The development of the DVHA's set of Guiding Principles for Benefit Design and Coverage Decisions began with gathering information from other states that have engaged in similar efforts as well as input from key Vermont stakeholders on their desired content and process for developing principles for Vermont. This information was then used as background at a face-to-face work session during which stakeholders developed a set of nine considerations they believed should be reflected in the Guiding Principles for Benefit Design and Coverage Decisions.

Following the work session, the DVHA refined those considerations into a set of principles, ensuring that they reflected the mission of the DVHA, the values of Vermonters, were in alignment with the principles included in Act 48, and were implementable.

GUIDING PRINCIPLES FOR BENEFIT DESIGN AND COVERAGE DECISIONS

The following principles were developed through this process and will guide the DVHA when making any benefit design or coverage decisions, including decisions about social services provided by other departments within the Agency of Human Services. Using these guiding principles will not preclude the Agency from considering individual circumstances, as appropriate. The principles are not presented in any order of priority.

- 1. *Transparent:*** The process for designing benefits and making coverage decisions should be transparent with the opportunity for public engagement.
- 2. *Evidence-Based:*** Decisions should be based on research evidence, with priority given to the best available evidence, as determined by an established hierarchy of evidence quality (e.g., GRADE, AHRQ).
- 3. *Continuously Improving:*** Covered benefits should be continuously monitored for effectiveness and reviewed and reevaluated as appropriate.
- 4. *Focused on Wellness:*** Benefit design and coverage decisions should maximize population health and the prevention of illness.
- 5. *Balanced:*** Benefit decisions should balance value, cost, and access.
- 6. *Ethical:*** Benefit decisions should be ethical.
- 7. *Holistic:*** Benefit decisions will recognize that healthcare is only one factor affecting health and must be balanced with other needs.

CONCLUSION

Using the valuable input of key Vermont stakeholders, examples of similar work done in other states, and careful consideration of the mission of the DVHA and values of Vermonters, the DVHA has developed a set of Guiding Principles for Benefit Design and Coverage Decisions. These guiding principles will be used by the DVHA, its advisory boards, and other Agency of Human Services departments to make difficult health coverage decisions.

The DVHA will continue to work with the participating stakeholders, including advisory boards and the Agency of Human Services Commissioners, on how best to incorporate the principles into current decision-making processes and evaluate whether system adjustments need to be made. Implementation and use of these principles in coverage decision-making provide Vermont with a clear framework for weighing effectiveness and costs of health care interventions, supporting evidence-based decision-making and wise use of limited resources.

BACKGROUND

Vermont faces budget constraints in Medicaid that restrict its ability to provide open ended access to medical services. As a result, the State must ensure that the services it does provide are the most effective at improving the health of beneficiaries. To do so, the Department of Vermont Health Access (DVHA) must be able to determine the clinical value of health services using a well designed appraisal framework based upon credible research methods. The process for applying this research to policy must be driven by a set of organizing principles based on the values of Vermonters applied in a logical and transparent process. The DVHA contracted with the Center for Evidence-based Policy (CEbP) at Oregon Health & Science University to support the process of developing these principles and how to apply them.

This report describes the process used to develop the DVHA's set of Guiding Principles for Benefit Design and Coverage Decisions. This process included four main components:

1. *Identify examples of principles and lessons learned from other states that have engaged in similar efforts.*
2. *Gather feedback from key Vermont stakeholders on the content and process for developing principles for Vermont.*
3. *Facilitate a face-to-face work session with stakeholders to develop a draft set of principles.*
4. *Incorporate stakeholder review of the draft principles.*

The first two components, identifying examples and principles from other states that have engaged in similar efforts and gathering feedback from key Vermont stakeholders, provided background information for the subsequent face-to-face work session. Work session participants used that information along with an overview of the current Vermont Medicaid benefit decision-making process to develop a set of nine key considerations that they believed should be reflected in the Guiding Principles for Benefit Design and Coverage Decisions.

Following the work session, the DVHA staff transformed the nine guiding principle considerations into a draft set of Guiding Principles for Benefit Design and Coverage Decisions. In the final step in the process and in alignment with Vermont's strong sense of community and collaboration, the DVHA solicited the input of key stakeholders, including the

KEY TERMS

The following definitions were developed by DVHA and referred to throughout the principle development process.

Principle

A fundamental norm, rule, or value that represents what is desirable and positive for a person, group, organization, or community, and help it in determining the rightfulness or wrongfulness of its actions. Principles are more basic than policy and objectives, and are meant to govern both.

Benefit Design

The process used to determine which benefits or the level of benefits that will be offered to beneficiaries, including the interventions covered, the degree to which beneficiaries will be expected to share the costs of such interventions, and how beneficiaries can access medical care through the health plan.

Coverage Decisions

Decisions about which health services to include within a benefit package.

Clinical Utilization Review Board (CURB) and the Drug Utilization Review Board (DURB), before finalizing the principles.

CURRENT PROCESS

The current process used by the DVHA to make benefit design and coverage decisions is focused primarily on the annual code review of new Current Procedural Terminology (CPT) codes released by the American Medical Association (AMA) and Healthcare Common Procedure Coding System (HCPCS) codes released by CMS. As new codes are released, the DVHA staff determine how each new code will be integrated into the current benefits.

There are a number of considerations taken into account by the DVHA staff when making Medicaid coverage decisions. Those considerations include:

- Medicaid Regulations;
- Whether the procedure or service is approved by the Food and Drug Administration (FDA);
- Whether the procedure or service is commonly performed by health care professionals regionally and/or nationally;
- Whether the procedure or service's clinical efficacy is proven and documented (e.g., evidence reviews, clinical studies, peer reviewed literature);
- Whether other/similar procedures are currently covered/not covered by Medicaid and/or regional and private insurers;
- Input of experts and providers.

While the current process provides a structure for making coverage decisions for new codes, it doesn't effectively support broader decision-making. The DVHA identified a need for a decision-making framework that allows consideration of all interventions to provide Vermonters enrolled in its services with health coverage that is both clinically appropriate and cost effective. The intent is that the principles developed through this process support a framework that allows the DVHA to achieve an optimal balance between available resources and covered services.

PACESETTER STATE INTERVIEWS

The first step in this process was to learn from the experiences of other states. The DVHA requested that CEBP conduct a literature scan to identify states that have developed and are using principles to make benefit design and coverage decisions. The literature scan focused

primarily on a search of policy sources, using the last ten years as a search period. Search terms included: “benefit design,” “benefit principle,” “benefit prioritization,” “coverage principle,” “benefit redesign,” and “coverage criteria.” Sources searched include AcademyHealth, Alliance for Healthcare Reform, Center for Budget and Policy Priorities, Center for Health Care Strategies, Center for Studying Health System Change, Commonwealth Fund, *Health Affairs*, Health Systems Evidence, Kaiser Family Foundation, Mathematica Policy Research, National Academy for State Health Policy, RAND, Robert Wood Johnson Foundation, the Urban Institute, the National Association of State Medicaid Directors, the National Conference of State Legislatures, National Governors Association, the Centers for Medicare and Medicaid Services, and Google. Additionally, articles identified through previous work addressing benefit design were included.

The results of the scan were used by the DVHA to select six pacesetter states, including Colorado, Maine, Massachusetts, New York, Oregon, and Washington. Representatives from these states were interviewed about the principles they use to guide benefit design and coverage decisions, and how those principles were developed and implemented. A complete list of the interview questions can be found in Appendix A.

Additional research included compiling documents related to state-specific benefit design initiatives. A Google search and searches of state-specific websites were conducted. Information extracted from those documents is included in the state interview summaries found in Appendix B.

The following section includes a summary of lessons learned from the six pacesetter states, common principles/considerations, and a description of the development and implementation processes used by the states.

LESSONS FROM PACESETTER STATES

During the interviews, pacesetter state representatives were asked about lessons they learned during the development and implementation of their benefit design and coverage decision principles. The interviewees shared similar experiences, including the following lessons learned:

- States have found that it is valuable to have an agreed upon set of principles for making benefit design and coverage decisions.
- States have taken different approaches to developing and implementing principles based on their individual state’s culture, needs, and structure.
- Stakeholder engagement is key to the success of developing and implementing principles.
- Even though the decision-making processes may change, the principles should stay the same.
- The development of the principles is easier than their implementation.
- All decisions should tie back to the principles.

COMMON PRINCIPLE THEMES

Although the six pacesetter states each used a different process to develop their principles, they shared a number of common themes. Those common themes are listed below with the number of states sharing the principle listed in parentheses. A summary of all pacesetter state principles is provided in Appendix B.

- When assessing benefits, harms, and costs, use high-quality empirical evidence appraisals to support decision-making. (6)
- Prioritize the use of safe, effective, and high-value care and discourage the overuse of inappropriate care. (5)
- Use a transparent decision-making process that allows for public input and engagement. (3)
- Intervention costs and resource limitations will be considered as part of decision-making. (3)
- All members/citizens should be treated equitably. (2)
- Patients should have access to individualized treatment. (2)

KEY VERMONT STAKEHOLDER INTERVIEWS AND SURVEY

In addition to learning from the experiences of other states, the DVHA recognizes the value of gathering input from local stakeholders and requested that CEbP solicit input from key Vermont stakeholders via phone interviews and a web survey. Both mechanisms provided stakeholders the opportunity for input in the development of Vermont's Benefit Design and Coverage Decision Principles. All participants were selected by the DVHA and included representatives from Blueprint for Health, Clinical Utilization Review Board, Drug Utilization Review Board, DVHA Unit Directors, Green Mountain Care Board, Legislators, Medicaid and Exchange Advisory Board, Vermont Department of Health, Vermont Department of Mental Health, Vermont Department of Disabilities, Aging and Independent Living, Vermont Medical Society, Vermont Department of Corrections and Vermont Agency of Human Services central office. A comprehensive list of stakeholders who participated in the process can be found in Appendix C. A total of 17 interviews were conducted and 17 survey responses were received for a total of 34 responses. The questions used in the phone interviews and web survey were identical (See Appendix D).

All responses are summarized below by question with the number of respondents for each question noted at the end.

Question 1: Please describe how benefit design and coverage decisions are currently made in Vermont state health programs, such as Medicaid.

Stakeholders expressed a range of understanding and perspectives on how benefit design and coverage decisions are currently made, which included 11 respondents sharing that they were not familiar enough with the process to describe it. The responses of those who were familiar with the process included:

- Decisions are made through the legislative and budget processes. (12)
- Decisions are made by the Clinical Utilization Review Board/Drug Utilization Review Board. (8)
- DVHA makes decisions in response to patient/provider requests. (6)
- Decisions are made based on legacy/history, i.e., if a service has been covered in the past, it will be covered in the future. (4)

Question 2: What do you believe are strengths of the current approach to making benefit design decisions?

Stakeholders identified the following strengths of the current benefit design and coverage decision process.

- Provides opportunity for stakeholder input; (15)
- Provides flexibility and responsiveness to diverse needs and requests; (9)
- Uses evidence based studies/practice; (6)
- Allows for comprehensiveness of the benefit package; (5)
- Includes strong clinical staff; (1)
- Supports the State's value that all people ought to be covered; (1)
- Maintains consistency in program redesign and strategic coordination of all health services; (1)
- Incorporates the utilization review process. (1)

Question 3: What do you believe are challenges of the current approach to making benefit design decisions?

Stakeholders identified the following challenges related to the current benefit design and coverage decision process.

- Lack of cross agency coordination; (17)
- Challenges to getting and using the right data and measurements; (7)
- Advocates may have a greater impact on decisions than evidence; (5)

- A tendency for the process to move slowly; (4)
- Lack of transparency; (3)
- Challenge to meet the expectations of patients within the available resources; (2)
- Current practices are influenced by past practices; (1)
- Difficult to keep up with emerging technology. (1)

Question 4: What factors should be considered when developing principles for benefit design and coverage decisions?

Stakeholders provided a range of considerations that need to be taken into account when developing the principles. They included:

- Decisions need to be evidence-based. (14)
- Decisions need to consider cost and cost-benefit. (13)
- The impact of a decision on the population needs to be considered. (10)
- The needs and circumstances of individuals need to be considered. (9)
- Quality and outcome measures need to be tracked. (8)
- A system-wide approach needs to be taken. (8)
- Coverage should focus on preventive services. (6)
- Stakeholder support and engagement should be integrated into the process. (6)
- The administrative burden should be minimized. (2)
- Incentives for good performance and achieving outcomes should be considered. (1)
- Decisions need to be sustainable and made for the long term. (1)

Question 5: If you had to prioritize three principles you believe are important to consider when making benefit design and coverage decisions, what would they be?

When asked to identify potential principles to guide the benefit design and decision process, the stakeholders indicated the following:

- Benefits should be evaluated for effectiveness using clinical evidence. (24)
- Benefits should be evaluated for cost impacts. (19)
- Benefits should take into consideration the needs, circumstances, and preferences of individuals. (9)
- The outcomes and impact of benefit changes should be measured. (8)
- Preventive services should be prioritized. (7)

- The accessibility of services and providers should be considered. (6)
- Benefit design should take into account the administrative effort required and aim to reduce fraud and waste. (5)
- Public and stakeholder input should be solicited and incorporated. (5)
- Providers should receive incentives for delivery of efficient and effective care. (3)
- Benefits should maximize the health of the population. (2)
- Benefits should be justifiable to taxpayers. (1)

Question 6: Vermont has a reputation for having a strong sense of community and for working together to address serious issues. Do you foresee challenges in gaining broad consensus around these principles?

Overall, there was agreement that reaching consensus is possible and that although there may be disagreement, everyone works well together (15). Some interviewees saw the issue of implementation of the principles as the key challenge (6).

Question 7: Please describe three stakeholders you believe should be included in the process

Interviewees recommended the following stakeholders be included in the benefit design principle process.

- Providers of health care; (19)
- Other agencies and departments; (15)
- Patient and consumer advocacy organizations; (11)
- Patients/consumers; (11)
- Advisory boards and commissions; (8)
- Other payers/insurers; (5)
- Policy makers. (5)

FACE-TO-FACE WORK SESSION

OVERVIEW

Following the completion of the initial literature scan, pacesetter state interviews, and interviews/survey of key Vermont stakeholders, a face-to-face work session was convened. The DVHA invited 22 key Vermont stakeholders to participate in a one-day work session facilitated by CEbP. The eighteen individuals who were able to participate are included in Appendix C. The work session had three primary objectives:

- Understand the basics of evidence informed policy-making;
- Develop a draft set of principles for use in DVHA benefit design decision-making;
- Share a draft framework for incorporating those principles into the decision-making process.

The work session agenda included a presentation by CEbP staff on the use of principles in evidence-informed benefit design processes, break out sessions on principle development, and a review of next steps. A detailed agenda is provided in Appendix E.

The Use of Principles in Evidence-informed Benefit Design Processes

The focus of the first agenda item, the use of principles in evidence-informed benefit design processes, was to provide background and common understanding as participants began developing a set of draft principles for benefit design decision-making. The presentation began with an overview of evidence-informed policy, which was defined as:

An approach to policy decisions intended to ensure that decision-making is well informed by the best available evidence and is characterized by accessing and appraising all relevant evidence in a systematic and transparent manner as an input into the policymaking process.

An overview and examples of systematic reviews and randomized controlled trials were used to illustrate the approach. In addition, strategies for supporting the use of evidence were highlighted, including:

- Supporting change in organizational culture and values to better support evidence-based decisions (leadership, networks, regular meetings);
- Setting priorities for obtaining evidence;
- Building capacity through skilled staff and evidence resources ;
- Clarifying methods for assessing quality and applicability;
- Developing a process for using research to inform decisions (e.g., OR Guidelines, WA HTA);
- Monitoring and evaluating policies.

Following the overview of evidence-informed policymaking, participants were provided background information. This included an overview of the current decision-making process for Vermont Medicaid, a summary of pacesetter state interviews, and a summary of key stakeholder interviews. In addition, the principles included in Act 48, an act relating to a universal and unified health system in Vermont, were reviewed to ensure that draft principles would align with Act 48.

Principle Development

Working with this background information and a common understanding of expectations, participants broke into small groups to discuss considerations and principles that should be included in the final draft set of principles. The small groups then reconvened as a large group to discuss their work. There were a number of themes identified during this final discussion, including:

- Should improve the health of population, including the prioritization of preventive services and development of policies that encourage medical homes;
- Should be transparent and incorporate public and stakeholder input for larger classes or groups of services, and the use of website to achieve transparency and open issues to public;
- Covered benefits should be accessible;
- Should evaluate evidence of clinical efficacy and harm using a hierarchy of evidence to allow different types of evidence to be weighted differently (e.g. RCTs vs observational studies);
- Should balance cost, quality and access to improve health, as health care is only one factor affecting health and as stewards of public dollars, costs should be considered;
- Should consider the individual's health needs and values, with the following taken into consideration:
 - Should different approach be taken for rare conditions?
 - Should design of benefits include right of appeal?
 - Should give individuals options within range of clinical effectiveness (e.g., choice between physical therapy and meds);
 - Should not adopt benefits that people find onerous (i.e., not valued);
 - Should place burden of proof on individual requesting exception to non-coverage policies.
- The effect of policies should be evaluated by measuring outcomes and service impact after implementation;
- Benefits should be ethical, meaning they do good, do no harm, obligation to uphold social justice;

- Benefits should be continuously reviewed.

Work Session Output: Considerations for Guiding Principles

At the conclusion of the work session, participants came to agreement on a set of nine key considerations that should be reflected in the Guiding Principles for Benefit Design and Coverage Decisions. The key considerations were:

1. The process should be transparent with opportunity for public engagement.
2. Benefits should maximize prevention.
3. Covered benefits should be continuously reviewed and reevaluated.
4. Benefits should maximize the health of the population.
5. Circumstances of the individual should be considered in the decision-making process.
6. Benefit decisions should balance relative value, cost and access.
7. Benefits need to be ethical, meaning they do no harm, do good, are patient-centered, enhance social justice.
8. Decisions should be based on evidence as determined by an established hierarchy of evidence (e.g., GRADE, AHRQ).
9. Healthcare is only one factor affecting health and needs to be balanced with other needs.

Next Steps

The work session concluded with an overview of the draft framework for incorporating the principles into the decision-making process. During this time, the DVHA shared its intention to present the draft principles to the CURB and DURB for feedback and then work with these advisory boards to incorporate the principles into their decision-making processes. Once the principles are finalized, the DVHA will post them on its website to ensure that they are available to all providers and consumers.

Work Session Evaluations

At the conclusion of the work session, participants were asked to complete a short evaluation. Participants provided favorable feedback, with all agreeing or strongly agreeing that the work session, including the presentations, breakout groups, large and small group discussions, and meeting process and facilitation, were worthwhile and effective. A summary of the evaluations can be found in Appendix F.

DRAFT PRINCIPLES

The nine considerations for guiding principles developed by key Vermont stakeholders at the work session were further evaluated and refined by the DVHA staff to ensure that they reflected the mission of the DVHA, the values of Vermonters, were in alignment with the principles included in Act 48, and were implementable. In addition, a set of definitions was added to ensure that the principles would be interpreted consistently. The resulting draft principles are listed below.

GUIDING PRINCIPLES FOR BENEFIT DESIGN AND COVERAGE DECISIONS

The following principles will guide the Department of Vermont Health Access when making any benefit design or coverage decisions, including decisions about social services provided by other departments within the Agency of Human Services. Using these guiding principles will not preclude the Agency from considering individual circumstances, as appropriate. The principles are not presented in any order of priority.

1. **Transparent:** The process for designing benefits and making coverage decisions should be transparent with the opportunity for public engagement.
2. **Evidence-Based:** Decisions should be based on research evidence, with priority given to the best available evidence, as determined by an established hierarchy of evidence quality (e.g., GRADE, AHRQ).
3. **Continuously Improving:** Covered benefits should be continuously monitored for effectiveness and reviewed and reevaluated as appropriate.
4. **Focused on Wellness:** Benefit design and coverage decisions should maximize population health and the prevention of illness.
5. **Balanced:** Benefit decisions should balance value, cost, and access.
6. **Ethical:** Benefit decisions should be ethical.
7. **Holistic:** Benefit decisions will recognize that healthcare is only one factor affecting health and must be balanced with other needs.

DEFINITIONS

Benefit - A service or support that contributes to and promotes well-being.

Benefit Design - The process used to determine which benefits or the level of benefits that will be offered to members, including the interventions covered, the degree to which members will be expected to share the costs of such interventions, and how a member can access medical care through the health plan.

Coverage Decisions - Decisions about which health services to include within the benefit package.

Ethical - To do no harm, to do good, to do what is in the best interest of the individual, and to be equitable.

Principle - A fundamental norm, rule, or value that represents what is desirable and positive for a person, group, organization, or community, and help it in determining the rightfulness or wrongfulness of its actions. Principles are more basic than policy and objectives, and are meant to govern both.

STAKEHOLDER REVIEW AND DISSEMINATION OF PRINCIPLES

Following development of the draft principles at the face-to-face work session, the DVHA developed a plan for gathering additional input and disseminating the final principles to key stakeholders, including the public. The plan includes steps for gathering final input, and subsequently finalizing and disseminating the principles.

Two groups, the stakeholders who participated in the development of the draft principles and the end user advisory boards (CURB and DURB), were given an opportunity to provide final input on the draft principles and dissemination plan. The CURB and DURB members were asked to focus on the implementation approach and to provide input on enhancing the principles, while the stakeholders were provided an opportunity for final input on the principles. The principles were also shared with the MEAB.

Upon receipt of all final input, the DVHA will finalize the Guiding Principles for Benefit Design and Coverage Decisions and begin dissemination. The DVHA expects to finalize the principles by the end of April, 2013. The dissemination plan includes multiple communication methods to support broad knowledge and understanding. Starting internally, the DVHA will present the principles to the Vermont Agency of Human Services Commissioners and the DVHA management teams. Next they will be shared with the stakeholder groups that participated in the development of the principles as well as the CURB, DURB, MEAB, and Green Mountain Care Board. Finally, the principles will be communicated with providers and consumers through methods such as the DVHA website and an article in the *DVHA Provider Advisory* newsletter.

CONCLUSION

Using the valuable input of key Vermont stakeholders, examples of similar work done in other states, and careful consideration of the mission of the DVHA and values of Vermonters, the DVHA has developed a set of Guiding Principles for Benefit Design and Coverage Decisions. These guiding principles will be used by the DVHA and its advisory boards to make difficult health coverage decisions.

The DVHA will continue to work with the stakeholders involved in this process, including advisory boards and the Agency of Human Services Commissioners on how to best incorporate the principles into current processes and evaluate whether process changes need to be made. Implementation and use of these principles in coverage decision-making provides Vermont with a clear framework for weighing effectiveness and costs of health care interventions, supporting evidence-based decision-making and wise use of limited resources.

APPENDIX A. PACESETTER STATE INTERVIEW QUESTIONS

VERMONT BENEFIT DESIGN PRINCIPLES AND FRAMEWORK
STATE INTERVIEWS

Interviewer: _____ Date: _____
 State: _____ Agency/Department _____
 Interviewee Name: _____ Title: _____
 Email: _____ Phone number: _____

Thank you for agreeing to talk with me today. I would like to give you a little background about our project and then we will launch into the interview questions.

Due to rising healthcare costs and an increased strain on Medicaid resources, as well as evidence that not all healthcare interventions are equally effective in preserving and restoring health, the State of Vermont is exploring methods of making benefit design and coverage decisions that use an agreed upon set of principles. Vermont plans on using these principles to identify health services that are most beneficial, and those which can be reduced for cost savings without adversely affecting the health of beneficiaries of state health programs.

Vermont has contracted with the Center for Evidence-based Policy at Oregon Health & Science University to facilitate this process, and one of our initial tasks is to survey key states about whether or not they have developed similar principles, what process they used to develop their principles, and how the principles integrate into their benefit design and coverage decision-making process.

The interview will take thirty to forty minutes. None of the information you share will be disclosed beyond our work with Vermont without your permission. Is it OK if I audio record our conversation to help make sure I capture your responses accurately?

Interviewee gave recording permission Yes: _____ No: _____

Do you have any questions before we begin?

QUESTIONS

1. How does your state make decisions about benefit design and which services should be covered in state health programs?
2. Does your state have principles in place that guide those decisions?
 - a. Yes: Ask for a copy and go to Q3
 - b. No: go to Q11
3. Please describe your state's decision-making principles.
4. What process did your state use to develop these principles?

- a. What was most challenging about that process?
 - b. What about the process worked well?
5. Who were the three most critical stakeholders who participated in the development process?
- a. _____
 - b. _____
 - c. _____
6. Were there stakeholders who were not involved in your state's process, but who should have been?
7. Are there any quality assurance mechanisms in place to ensure that the principles are being used as intended to make coverage decisions?
8. Is there anyone else you think it would be beneficial to speak with about developing principles for benefit design and coverage decisions?
9. Is there anything else you would like to share with Vermont as they begin this project?

Thank you for your time and sharing your valuable insights.

END OF INTERVIEW

10. Does your state have plans to develop principles for benefit design and coverage decisions?
- a. Yes: go to Q12
 - b. No: go to Q13
11. Please describe your state's plans for developing principles.
12. Is there anyone else you think it would be beneficial to speak with about this topic?
13. Is there anything else you would like to share with Vermont as they begin this project?

Thank you for your time and sharing your valuable insights.

END OF INTERVIEW

APPENDIX B. PACESETTER STATE SUMMARIES

TABLE: PACESETTER STATE BENEFIT DESIGN AND DECISION PRINCIPLES

State (Type)	Principles
New York¹ (Principles)	<ol style="list-style-type: none"> 1. All Medicaid members will be treated equitably without discrimination so that they may attain the highest level of health 2. If Medicaid budgets are insufficient to support all potential services, then priorities must be set by the program among services to be provided based on evidence and effectiveness 3. Priorities in benefit design must maximize the health of the population served by the program and be based on an assessment of benefits, harms, and costs 4. When assessing benefits, harms, and costs, empirical evidence (when available and of high quality) will be critically appraised to determine its appropriateness for policy application and will be given more weight than subjective or expert opinion 5. Criteria to be considered for evaluation of specific services and benefits follow those of evidence-based health care 6. Considering cost and value as well as cost control through benefit design are legitimate as they support the ability of the state to provide the maximum number of services that are effective in improving the health of the population. This approach will make the most efficient use possible of available resources and maximize the public good. 7. A highly limited number of benefit decisions may require an individualized approach including those pertaining to rare or emerging clinical conditions for which a high level of evidence is not realistic; certain experimental treatments where no ‘standard of care’ exists; and/or, complex emergency circumstances 8. In the evaluation of services and benefit design, the outcomes of interest should include the preferences of patients, individual autonomy, and those outcomes generally of high value to patients, such as survival, function, symptoms, and quality of life 9. Evaluation of utilization, costs, and health outcomes, where feasible, should follow any ‘major’ benefit decisions in order to assess impact 10. Every attempt should be made to eliminate any conflict of interest in the use of clinical experts
Oregon (Principles)	<ol style="list-style-type: none"> 1. All citizens should have universal access to a basic level of care 2. Society is responsible for financing care for poor people 3. There must be a process to define a “basic” level of care 4. The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole 5. The health care delivery system must encourage use of services and procedures that are effective and appropriate, and discourage over-treatment 6. Health care is one important factor affecting health; funding for health care must be balanced with other programs that also affect health 7. Funding must be explicit and economically sustainable 8. There must be clear accountability for allocating resources and for the human consequences of funding decisions
Massachusetts (Considerations)	<ol style="list-style-type: none"> 1. Consider historic precedence, whether the benefit has been covered in the past 2. Consider the demand for services 3. Consider how the benefit contributes to overall wellness 4. Consider whether there is any evidence on the effectiveness of the service 5. Consider the clinical implications 6. Examine current customary practices in the industry 7. Look at the characteristics and scope of the population that will be affected 8. Understand the providers who will be affected

¹ Detailed criteria included in the New York principles are not included in this table, but can be found on pages 20 – 21.

State (Type)	Principles
Washington (Legislative Mandate)	<ol style="list-style-type: none"> 1. Promote excellent health care by investigating what works 2. Contract for impartial, peer reviewed evidence-based reports to support better decision making 3. Use the expertise of an independent committee of practicing health care providers to review the reports and make health care coverage decisions 4. Maintain an open process for nominations of health technologies and information gathering about selected technologies 5. Support a centralized location for state agencies to share information on other health care coverage decisions 6. Select six technologies in the first year and eight technologies in the second year for study and coverage decision
Maine (Considerations)	<ol style="list-style-type: none"> 1. Consider cost (greater emphasis for Medicaid) 2. Maximize prevention 3. Ensure benefits are ethical and efficacious 4. Provide comprehensive benefits through Dirigo Health
Colorado² (Principles)	<ol style="list-style-type: none"> 1. Not all health services are created equal 2. Too many unnecessary services are provided and services known to produce better health are not provided 3. If something costs more, patients are less likely to buy it; if something costs less, patients are more likely to buy it 4. Patients are interested in what happens to them 5. The best treatment for an individual may depend on their own goals and values 6. Use research and evidence-based medicine 7. Promote use of safe, effective, high-value care and discourage the overuse of inappropriate care 8. Respect unique health care needs of individuals 9. Effectively engage consumers in health care decision-making

PACESETTER STATE SUMMARIES

NEW YORK

In January 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) and charged it with finding ways to save money within the New York Medicaid program for the 2011-12 Fiscal Year. The MRT divided their work into two phases.

In Phase I, the MRT developed a package of reform proposals that achieved the Governor’s Medicaid budget target, introduced significant structural reforms, and achieved savings without cuts to eligibility. As part of the Phase 1 work, the MRT Basic Benefit Design Review Work Group developed a set of guiding principles that were applied when developing their redesign recommendations and that will be used when conducting future benefit reviews.

² Not used by Colorado Medicaid

In Phase 2, ten individual work groups were established and charged with creating a coordinated plan to ensure that the Medicaid program can function within a multi-year spending limit, improve program quality, and monitor the implementation of key recommendations from Phase 1.

Additional information on the Medicaid Redesign Team can be found at http://www.health.ny.gov/health_care/medicaid/redesign/

Decision-making principles

1. All Medicaid members will be treated equitably without discrimination so that they may attain the highest level of health
2. If Medicaid budgets are insufficient to support all potential services, then priorities must be set by the program among services to be provided based on evidence and effectiveness
3. Priorities in benefit design must maximize the health of the population served by the program and be based on an assessment of benefits, harms, and costs
4. When assessing benefits, harms, and costs, empirical evidence (when available and of high quality) will be critically appraised to determine its appropriateness for policy application and will be given more weight than subjective or expert opinion. The hierarchy of evidence used for coverage decisions includes:
 - a. Type I (highest): meta-analysis or systematic review of multiple well-designed randomized controlled trials
 - b. Type II: one or more well-designed randomized controlled trials
 - c. Type III: well-designed studies that could include nonrandomized controlled, pre-post, cohort, case-control, cross-sectional, observational studies
 - d. Type IV: expert panel opinion/ high quality professional guidelines
 - e. Type V (lowest): single expert, case report
5. Criteria to be considered for evaluation of specific services and benefits follow those of evidence-based health care, and include:
 - a. Evidence that the service is better than receiving no service for the specific clinical condition(s) or populations
 - b. the added benefit per added cost compares favorably with other treatments for the same condition
 - c. Evidence that access to less expensive interventions does not create undue burden for individuals
 - d. Evidence that benefits outweigh harms in improving health
 - e. The burden of presenting evidence for the above criteria lies with those advocating the use of the service

- f. Level of evidence will be specified in accord with typology described above and reassessed when sufficient new evidence would suggest a possible change in benefit coverage
6. Considering cost and value as well as cost control through benefit design are legitimate as they support the ability of the state to provide the maximum number of services that are effective in improving the health of the population. This approach will make the most efficient use possible of available resources and maximize the public good. Criteria for excluding or limiting benefits should focus on those services in which:
 - a. Costs are high and evidence for clinical effectiveness is highly variable or low; or, the clinical intervention (product or service) is overused compared with evidence-based appropriateness criteria
 - b. Evidence of additional value (benefits to cost) compared with other treatments for the same condition is low
 7. A highly limited number of benefit decisions may require an individualized approach including those pertaining to rare or emerging clinical conditions for which a high level of evidence is not realistic; certain experimental treatments where no 'standard of care' exists; and/or, complex emergency circumstances
 8. In the evaluation of services and benefit design, the outcomes of interest should include the preferences of patients, individual autonomy, and those outcomes generally of high value to patients, such as survival, function, symptoms, and quality of life
 9. Evaluation of utilization, costs, and health outcomes, where feasible, should follow any 'major' benefit decisions in order to assess impact
 10. Every attempt should be made to eliminate any conflict of interest in the use of clinical experts

Benefit design decision process

- Benefit review is initiated during budget cycles; through ongoing review of HCPCS, CPT codes and new technologies; and proposals from the legislature, providers, vendors, and patients
- Evidence is gathered and evaluated internally
- Considerations include what other insurers are doing
- Considerations include clinical determination about effectiveness
- Considerations include financial impacts
- Final determinations combine clinical and fiscal factors

Process used to develop decision-making principles

- The Medicaid Redesign Team was tasked with reviewing benefits, not establishing principles
- It quickly became clear that principles would be helpful in making decisions
- Stakeholders were engaged, and included provider organizations, health plans, consumers, clinical experts, and experts in evidence review

- Challenges addressed included how to frame benefit package as having maximum value without triggering fears of rationing; and how to incorporate individual exceptions when making benefit decisions for a population
- The principles have been helpful in guiding benefit evaluation, but the challenge has been in how to execute them; it can be difficult to make the words on paper a reality

OREGON

In 1987, Oregon legislated a process to restructure how Medicaid benefits would be defined based on explicit priorities established by an independent commission through a public process. A group convened by then Senate President John Kitzhaber, established a set of principles to guide the development of the process for prioritizing benefits.

In 1989, legislation created the Health Services Commission, and charged it with developing and updating the list of prioritized health services. The first methodology and resulting list was approved and implemented in 1994. Further changes were made to the methodology in 2006 and were reflected in the list implemented January 2008. The Health Services Commission was replaced by the Health Evidence Review Commission in January, 2012.

Additional information on the Health Evidence Review Commission can be found at

<http://www.oregon.gov/OHA/OHPR/HSC/Pages/index.aspx>

Decision-making principles

1. All citizens should have universal access to a basic level of care
2. Society is responsible for financing care for poor people
3. There must be a process to define a “basic” level of care
4. The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole
5. The health care delivery system must encourage use of services and procedures that are effective and appropriate, and discourage over-treatment
6. Health care is one important factor affecting health; funding for health care must be balanced with other programs that also affect health
7. Funding must be explicit and economically sustainable
8. There must be clear accountability for allocating resources and for the human consequences of funding decisions

Benefit design decision process

- The Health Evidence Review Commission develops and maintains a Prioritized List of Health Services ranked “from the most important to the least important”; cost-effectiveness is considered

- Biennial review is conducted during which the entire list is reviewed and updated; minor changes based on new information may be made every six months
- The Prioritized List is structured as 692 condition-treatment pairs matching ICD 9 codes with CPT and HCPCS procedure codes
- Pairs are first put into broad categories then scored based on population and individual impact measures; further refinement is done manually
- State developed Guidance Statements are used to specify a level of detail for when a service is covered, if that detail is not adequately reflected in the codes
- The process is public and transparent

Process used to develop decision-making principles

- The current methodology was developed in 2006 and implemented in 2008; it increased the emphasis on population health and prevention
- The process links methodology to public values and make funding decisions explicit and transparent
- Challenges included creating a methodology the federal government would accept and maintaining the diagnosis-treatment code pairings
- A strength of the process included the willingness of the commission members to set aside their own interests and commit many hours of their time

MASSACHUSETTS

The Massachusetts Medicaid Program does not have a set of formally adopted principles to guide their benefit decisions, but does has a set of established considerations that are used in conjunction with a formal decision-making process. The considerations and process is listed below.

Decision-making considerations

1. Consider historic precedence, whether the benefit has been covered in the past
2. Consider the demand for services
3. Consider how the benefit contributes to overall wellness
4. Consider whether there is any evidence on the effectiveness of the service
5. Consider the clinical implications
6. Examine current customary practices in the industry
7. Look at the characteristics and scope of the population that will be affected
8. Understand the providers who will be affected

Benefit design decision process

- Changes to benefits are sometimes made during budget crises without much input from stakeholders; the department evaluates optional benefits and decide whether to continue covering services
- During regular budget cycles Mass Health gathers input from stakeholders and members through forums and postings
- Changes are vetted at all levels of the organization
- Major changes are communicated to sister programs such as the Connector, the Division of Unemployment Assistance, and the Department of Health Care Finance and Policy

Process used to develop decision-making considerations

- Although there was no formal process used to develop the current principles, stakeholders are a significant part of all benefit decisions made by Mass Health

WASHINGTON

In 2006, the Washington state legislature created the Health Technology Assessment Program (HTA) to ensure that medical treatments and services paid for with state health care dollars, including Medicaid services, are evaluated for safety and effectiveness. Although the HTA does not have a set of adopted principles to guide their benefit decisions, they do have a mandate that serves to guide their work.

Mandate

1. Promote excellent health care by investigating what works
2. Contract for impartial, peer reviewed evidence-based reports to support better decision making
3. Use the expertise of an independent committee of practicing health care providers to review the reports and make health care coverage decisions
4. Maintain an open process for nominations of health technologies and information gathering about selected technologies
5. Support a centralized location for state agencies to share information on other health care coverage decisions
6. Select six technologies in the first year and eight technologies in the second year for study and coverage decision

Benefit decision process

The HTA reviews available evidence, using a technology evaluation matrix, to determine if a new technology, new indication, or existing technology approved by the Food and Drug Administration (FDA) should be a covered service. The matrix is used to:

- Determine its efficacy, effectiveness, and safety;
- Determine its impact on health outcomes;

- Identify indications for use;
- Identify potential for misuse or abuse; and
- Compare to alternative technologies to assess benefit vs. harm and cost effectiveness

MAINE

In 2003, Maine underwent two efforts to redefine public health care. The first effort was the development of a Basic Benefit Plan for Maine Medicaid in response to a budget deficit. The second effort was Dirigo Health Reform, which Governor Baldacci signed into law with the intention that all Maine citizens would have access to quality and affordable health care. The reforms included initiatives in the private sector such as coordination between hospitals and other providers; transition to electronic medical records and claims; and increasing transparency of cost and financial data for providers and insurance companies. DirigoChoice, a public/private partnership between the Dirigo Health Agency and Harvard Pilgrim Health Care through a subsidy program for small employers, the self-employed, and individuals, was a product of that work and is still in operation.

Additional information on the history of Dirigo Health Reform can be found at http://www.dirigohealth.maine.gov/Pages/policy_history.html

Additional information on the current programs operated by the Dirigo Health Agency can be found at <http://www.dirigohealth.maine.gov/>

Decision-making considerations: Dirigo Health and Maine Medicaid

1. Consider cost (greater emphasis for Medicaid)
2. Maximize prevention
3. Ensure benefits are ethical and efficacious
4. Provide comprehensive benefits through Dirigo Health

Benefit design decision process: 2003-2004 initiatives

Dirigo Health

- A Health Action Team made up of 26 stakeholders utilized a benefit design subcommittee to provide recommendations in the Team's final report
- The Dirigo Board of Directors had final authority in applying principles and making benefit design and coverage decisions for included plans

Medicaid Basic Health Plan

- Conducted within the agency due to the related budget deficit and accelerated timeline
- Process considered cost drivers, utilization, and worked with Medical Director to consider efficacy and determine which benefits could be reduced, changed, or substituted

Process used to develop decision-making considerations

Dirigo Health

- The Health Action Team produced a report, “Dirigo Health Reform Health Action Team Report” which outlined their considerations
- The Board process worked well, allowing for public discussion of broad ideas around how benefits should be structured
- The process allowed for discussion of whether specific benefits should be excluded, or if there should be limitations on service which put responsibility on the care delivery system to determine appropriate utilization

Medicaid Basic Health Plan

- Decisions were determined by staff working on benefit redesign
- Some stakeholders may have felt excluded from the process and expressed resistance after the plan was released
- Engaging consumers at the right level but continuing to move forward was challenging

COLORADO ENGAGED BENEFIT DESIGN

Engaged Benefit Design (EBD) is a tool that was commissioned by the State of Colorado and developed by Engaged Public, a public policy strategy firm, and a team of Colorado medical experts. It was developed in 2009 as a new approach to healthcare benefit design that provides resources and incentives for patients and their healthcare providers to make healthcare decisions based on patient values and medical evidence.

The Colorado Department of Health Care Policy and Financing, which administers Colorado Medicaid, contributed funding and participated on the Engaged Benefit Design Medical Advisory Council and Project Advisory Committee, but has not implemented Engaged Benefit Design into their Medicaid program. To date, Engaged Benefit Design has only been implemented in one place, with the employees and dependents of the San Luis Valley Regional Medical Center in Alamosa, Colorado.

Additional information on the Engaged Benefit Design initiative can be found at

<http://www.engagedbenefitdesign.org/>

Decision-making principles

1. Not all health services are created equal
2. Too many unnecessary services are provided and services known to produce better health are not provided
3. If something costs more, patients are less likely to buy it; if something costs less, patients are more likely to buy it
4. Patients are interested in what happens to them
5. The best treatment for an individual may depend on their own goals and values

6. Use research and evidence-based medicine
7. Promote use of safe, effective, high-value care and discourage the overuse of inappropriate care
8. Respect unique health care needs of individuals
9. Effectively engage consumers in health care decision-making

Benefit design decision process

- The Engaged Benefit Medical Advisory Council addressed two types of services:
 - Preference-sensitive services with evidence of overuse
 - Services with evidence of effectiveness that should be promoted

Process used to develop decision-making principles

- Principles were developed by a small internal group of Engaged Benefit Design staff
- External perspectives, including those from the public, were solicited
- Principles were applied at a very high level rather than at the individual service level
- Challenges included:
 - Narrowing or limiting the number of services, in a way that impacts quality and cost,
 - Implementing cost-sharing in Medicaid,
 - Ensuring the appropriate use of an escape clause for use when services might be necessary

APPENDIX C. VERMONT KEY STAKEHOLDER PARTICIPANTS

The following stakeholders participated in the interview and/or onsite work session:

Sen. Claire Ayer, Legislator
 Melissa Bailey, Vermont Agency of Human Services
 Stephanie Beck, DVHA Policy Director
 Dr. Delores Burroughs-Biron, Clinical Utilization Review Board
 Barbara Cimaglio, Department of Health
 Bill Clark, DVHA Provider and Member Services Director
 Ron Clark, DVHA Program Integrity Director
 Dr. Lisa Dulsky Watkins, Blueprint for Health Associate Director
 Dr. Michael Farber, DVHA Medical Director
 Rep. Michael Fisher, Legislator
 Eileen Girling, DVHA Vermont Chronic Care Initiative Director
 Carrie Hathaway, DVHA Financial Director III
 Dr. Karen Hein, Green Mountain Care Board
 Bard Hill, Department of Disabilities, Aging and Independent Living (DAIL) Information & Data Director
 Nancy Hogue, DVHA Pharmacy Director
 Dr. Breena Holmes, Department of Health
 Amanda Kennedy, Drug Utilization Review Board
 Trinka Kerr, Medicaid and Exchange Advisory Board
 Sen. Jane Kitchel, Legislator
 Sara Lane, DAIL Choices for Care-Home Based Services
 Mark Larson, DVHA Commissioner
 Michelle Lavallet, DVHA Health Reform Portfolio Director
 Suzanne Leavitt, DAIL Choices for Care-Nursing Home Services
 Robin Lunge, Director of Health Care Reform
 Marybeth McCaffrey, DAIL Division of Disability and Aging Services
 Michael McAdoo, DVHA Substance Abuse Director
 Clare McFadden, DAIL Division of Disability and Aging Services
 Madeleine Mongan, Vermont Medical Society
 Dr. Mark Pasanen, Drug Utilization Review Board
 Dr. Anya Rader Wallack, Green Mountain Care Board
 Dr. Allan Ramsey, Green Mountain Care Board
 Frank Reed, Department of Mental Health
 Suzanne Santarcangelo, Vermont Agency of Human Services
 Donna Sutton Fay, Medicaid and Exchange Advisory Board
 Beth Tanzman, Blueprint for Health Assistant Director
 Cynthia Thomas, DVHA Quality Improvement Director
 Lindsey Tucker, DVHA Health Benefits Exchange Deputy Commissioner
 Cindy Walcott, Department for Children and Families (DCF) Deputy Commissioner
 Dr. Richard Wasserman, Clinical Utilization Review Board
 Dr. Susan Wehry, DAIL Commissioner

APPENDIX D. VERMONT KEY STAKEHOLDER INTERVIEW QUESTIONS

VERMONT BENEFIT DESIGN PRINCIPLES AND FRAMEWORK
VERMONT KEY STAKEHOLDER INTERVIEWS

Interviewer: _____ Date: _____
 Interviewee Name: _____ Title: _____
 Agency/Department _____
 Email: _____ Phone number: _____

Thank you for agreeing to talk with me today. I would like to give you a little background about our project and then move into the interview questions.

The Department of Vermont Health Access is working to establish and agreed upon set of principles that will be used to identify health services that are most beneficial, and those which can be reduced for cost savings without adversely affecting the health of beneficiaries of state health programs, such as Medicaid.

Vermont has contracted with the Center for Evidence-based Policy at Oregon Health & Sciences University to facilitate this process, and we are starting by interviewing key Vermont stakeholders, such as yourself as well as other states that are doing similar work. The information gathered from both sets of interviews will be summarized and used to inform the discussion at an in-person work session this October that will focus on developing a set of principles and a decision-making framework to guide future benefit design and coverage decisions for Vermont Medicaid.

The interview will take twenty to thirty minutes. The information you share will be summarized in a report provided to Vermont and will not be attributed to you personally without your permission. Is it OK if I audio record our conversation to help make sure I capture your responses accurately?

Interviewee gave recording permission Yes: _____ No: _____

Do you have any questions before we begin?

QUESTIONS

1. During our interview we will be focusing on principles that will guide benefit design and coverage decisions, not specific services. Keeping this in mind, could you talk a little about how benefit design and coverage decisions are currently made in Vermont state health programs, such as Medicaid?
 - a. If they know, document response and go to Q2.
 - b. If they do not know, go to Q4.

2. What do you believe are strengths of the current approach to making benefit design decisions?
3. What do you believe are challenges of the current approach to making benefit design decisions?
4. What factors should be considered when developing principles for benefit design and coverage decisions?
5. If you had to prioritize three principles you believe are important to consider when making benefit design and coverage decisions, what would they be? (ex: Service priorities must be set based on evidence and effectiveness)
 - a. _____
 - b. _____
 - c. _____
6. Vermont has a reputation for having a strong sense of community and for working together to address serious issues. Do you foresee challenges in gaining broad consensus around these principles?
7. Please describe three stakeholders you believe should be included in the process and why you think their input will be valuable.
 - a. _____
 - b. _____
 - c. _____
8. As I mentioned, we will be facilitating the work session focused on developing principles for benefit design and coverage decisions. Is there anything else that you think would be helpful for us to know as we prepare for that work session?

Thank you for your time and sharing your valuable insights.

END OF INTERVIEW

APPENDIX E. FACE-TO-FACE WORK SESSION AGENDA

Department of Vermont Health Access: Principles for Benefit Design Decisions

Key Stakeholder Work Session

October 16, 2012, 8:15 am – 4:00 pm

Meeting Objectives:

- 1) Understand the basics of evidence informed policy-making
- 2) Develop a draft set of principles for use in the DVHA benefit design and coverage decision-making
- 3) Identify next steps for integrating principles into the decision-making framework

8:15 – 8:30 am	Coffee	
8:30 – 8:45 am	Welcome	Vicki Loner
8:45 - 9:20 am	Housekeeping <ul style="list-style-type: none"> • Agenda review • Warm up activity 	Stephanie Betteridge
9:20 – 10:30 am	The Use of Principles in Evidence-informed Benefit Design Processes <ul style="list-style-type: none"> • Current process for decision making in Vermont Medicaid • Overview of Evidence-informed policy • Results of pacesetter state interviews 	Daljit Clark, Mark Gibson, Stephanie Betteridge
10:30 - 10:45 am	Break	
10:45 – Noon	Principles for Evidence-informed Benefit Design – Vermont <ul style="list-style-type: none"> • Results from key Vermont stakeholder interviews & survey • Group discussion • Small group discussion 	Mark Gibson, Stephanie Betteridge
Noon – 12:30 pm	Lunch (provided)	
12:30 -2:30 pm	Principle Development <ul style="list-style-type: none"> • Small group discussion – continued • Agreement on draft set of principles • Framework for integrating principles into the benefit design process 	Mark Gibson, Stephanie Betteridge, Vicki Loner
2:30 - 2:45 pm	Break	
2:45 – 3:45 pm	Next Steps <ul style="list-style-type: none"> • Communication of principles 	Mark Gibson, Alison Little

GUIDING PRINCIPLES FOR BENEFIT DESIGN AND COVERAGE DECISIONS

- Data analysis and policy comparison
-

3:45 –4:00 pm

Closing

- Closing comments
 - Meeting evaluation
-

Vicki Loner, Mark
Gibson

APPENDIX F. FACE-TO-FACE WORK SESSION EVALUATION

VERMONT KEY STAKEHOLDER WORK SESSION

OCTOBER 16, 2012 - MEETING EVALUATION

*Rating Scale: 1 (Strongly Disagree), 2 (Disagree), 3 (Agree), 4 (Strongly Agree)***1. The informational presentations were worthwhile.**

Average Response = 3.46 (Agree - 7, Strongly Agree - 6)

2. The work session and breakout groups focused on principle development were worthwhile.

Average Response = 3.7 (Agree - 4, Strongly Agree - 9)

3. The meeting process and facilitation were effective.

Average Response = 3.77 (Agree - 3, Strongly Agree - 10)

4. The large and small group discussions were constructive.

Average Response = 3.77 (Agree - 3, Strongly Agree - 10)

5. I would have liked more discussion about:

- Goals of the entire project - a little more context. More about the data analysis and how you will apply principles to realizations in the data
- Patient outcomes, conflict of interest
- Implementation of principles
- Washington's HTA initiative
- The group had many questions about the current design process and probably could have used more time for that
- Examples to elucidate decisions made in healthcare expenditures

6. I would have liked less discussion about:

- Individual roles - I worry this opens the door for less evidence-based, more costly decisions
- I felt the morning presentation somewhat overemphasized the importance of evidence-based information to inform benefit design values
- The lecture on evidence-based medicine was too long and not totally on point relative to today's task on principle development
- Nothing - well balanced

7. Please add any other comments that will help improve this type of work session in the future.

- Overall great process and discussion
- Good facilitation for a challenging topic
- Overall, excellent job
- Liked having examples from other states and summary of the interviews
- Setting up pacesetter states on a grid with commonalities in addition to lengthier narratives
- I came away with the thought that our work on drafting principles was done in preparation to review the data from the top 100 services analysis
- I am amazed that the process worked! Nice job!

REFERENCES

- Cabinet for Health and Family Services, Department for Medicaid Services. (2006). Kentucky's Medicaid Transformation Initiative. KyHealth Choices. Retrieved from <http://www.chfs.ky.gov/NR/rdonlyres/70AC8C04-BDEF-4A64-AB06-45FEE8285A04/0/1115waiver.pdf>
- California Department of Health Services. (2005). Medi-Cal Redesign. Retrieved from http://www.dhcs.ca.gov/services/medi-cal/Documents/MCRedesignInitiatives/MCRedesign1_12_05fin.pdf
- Collins, S.R., Schoen, C., Davis, K., Gauthier, A.K., & Schoenbaum, S.C. (2007). A roadmap to health insurance for all: principles for reform. The Commonwealth Fund Commission on a High Performance Health System. Retrieved from <http://www.allhealth.org/briefingmaterials/cmwf-roadmap-931.pdf>
- Cookson, R., McCabe, C., Tsuchiya, A. (2008). Public healthcare resource allocation and the Rule of Rescue. *Journal of Medical Ethics*, 34, 540-544.
- DiPrete, B., & Coffman, D. (2007). A Brief History of Health Services Prioritization in Oregon. Retrieved from <http://cms.oregon.egov.com/oha/OHPR/HSC/docs/prioritizationhistory.pdf>
- Duow, K., Vondeling, H. (2006). Selection of new health technologies for assessment aimed at informing decision-making: a survey among horizon scanning systems. *International Journal of Technology Assessment in Health Care*, 22(2), 177-183.
- Elshaug, A.G., Moss, J.R., Littlejohns, P., Karnon, J., Merling, T.L., & Hiller, J.E. (2009). Identifying existing health care services that do not provide value for money. *Medical Journal of Australia*, 190(5), 269-273.
- Georgia Department of Community Health. (2012). Medicaid and CHIP Redesign Initiative. Retrieved from <http://dch.georgia.gov/medicaid-chip-redesign>
- Kenney, G., Pelletier, J.E., Costich, J.F. (2010). Medicaid Policy Changes in Kentucky under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges. State Health Access Reform Evaluation. Retrieved from <http://www.shadac.org/files/shadac/publications/KentuckyMedicaidDRACaseStudy.pdf>
- New York State Department of Health. (2011). Medicaid Redesign Team (MRT). Retrieved from http://www.health.ny.gov/health_care/medicaid/redesign/docs/basic_benefit_review_wrk_grp_final_rpt.pdf
- NY State Department of Health. (2011). Medicaid redesign team basic benefit review work group final recommendations. Retrieved from http://www.health.ny.gov/health_care/medicaid/redesign/docs/basic_benefit_review_wrk_grp_final_rpt.pdf

Oregon Health Authority. (n.d.). Prioritization Methodology. Oregon Health Policy and Research. Retrieved from <http://cms.oregon.egov.com/oha/OHPR/pages/herc/methodology.aspx>

Oregon Health Authority. (n.d.). Prioritized List of Health Services Methodology. Oregon Health Policy and Research. Retrieved from <http://cms.oregon.egov.com/oha/OHPR/pages/herc/methodology.aspx>

Paul-Reeff, T. (2010). Evidence-Based Benefit Design. Colorado Department of Health Care Policy and Financing. Retrieved from <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251679037208&ssbinary=true>

State of Colorado. (n.d.). Colorado Innovative Benefit Design Pilot. Colorado Department of Health Care Policy and Financing. Retrieved from <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251688454512&ssbinary=true>

Washington State Health Care Authority. (n.d.). Prioritization Criteria and Tools. Health Technology Assessment. Retrieved from http://www.hta.hca.wa.gov/documents/prioritization_criteria.pdf

West Virginia Department of Health and Human Resources. (2005). Medicaid Redesign Proposal. Retrieved from <http://www.wvdhhr.org/medRed/BMSRedesignFinal11705.pdf>