

Intensive Safety Net Policy Review Sessions

September 21, 2010 - 9:00-4:00 (coffee and refreshments at 8:30)

**Northwest Health Foundation – Bamboo Room
221 NW Second St., Suite 300, Portland, Oregon**

October 1, 2010 - 9:00-12:00 (coffee and refreshments at 8:30)

**Lloyd Satellite Office, Board Room (Suite 140)
1201 NE Lloyd Blvd., Portland, Oregon**

Goals:

- Provide concrete and specific feedback to the Oregon Health Policy Board and its committees as on how policies can be shaped to best support the needs of vulnerable populations
- Consider the future of the safety net over the next five to ten years in meeting the needs of vulnerable populations, building off the past work of the Safety Net Advisory Council and what is known about federal reform

Session Deliverables

- Written input to OHPB committees and committee staff
- Summary of recommendations and considerations to the OHPB

Agenda

September 21, 2010

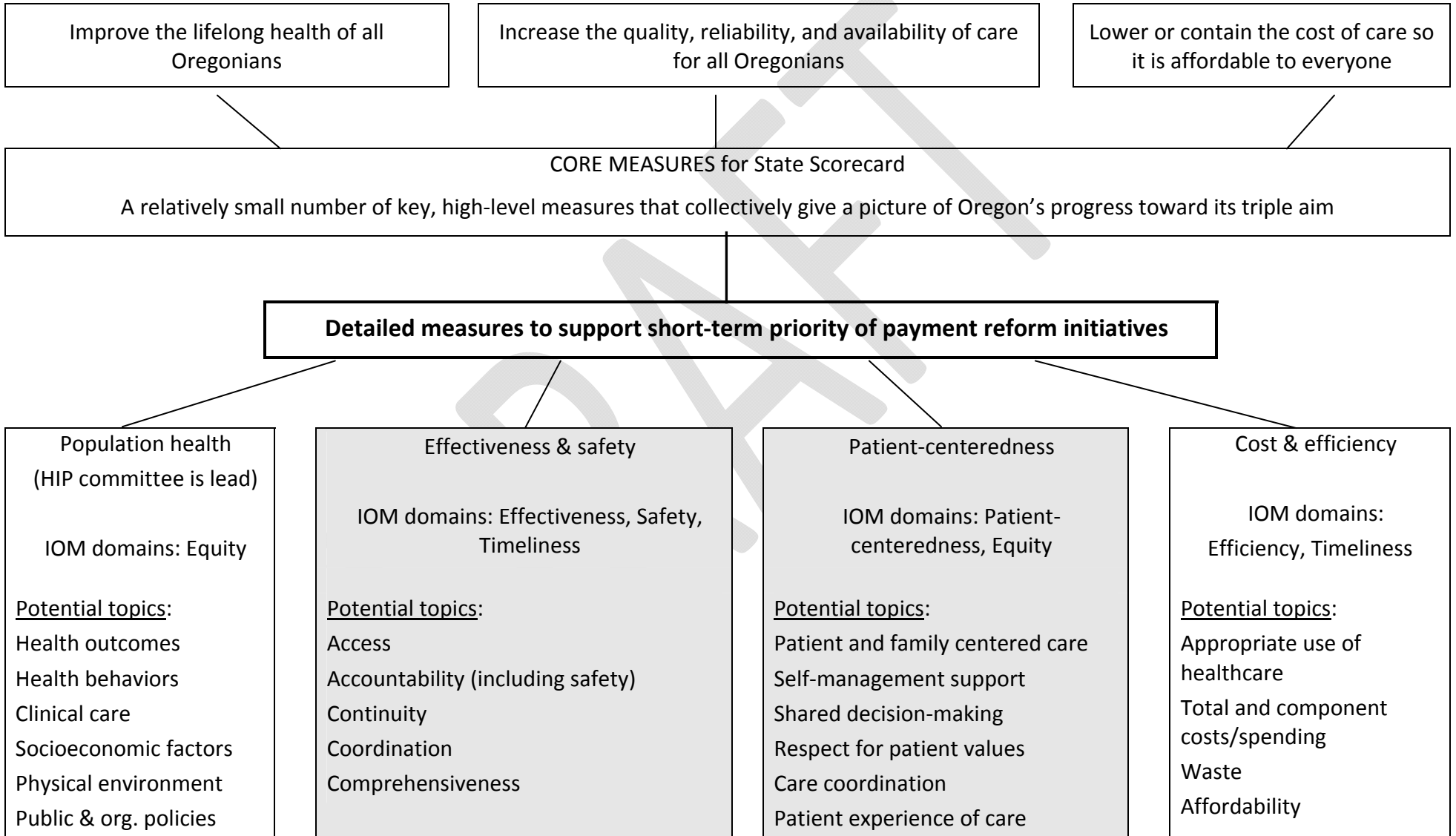
- Introductions and agenda overview
- Process and timeline review: How will SNAC inform the work of the OHPB and its committee recommendations?
- Vision discussion: What is the role of the safety net in the next 5-10 years?
- Questions to ask when reviewing committee work
 - What are the most pressing issues?
 - What is missing from the committee work?
 - Where can considerations for the care needs of vulnerable populations be best integrated both short-term and long-term?
 - What concrete next steps are needed?
 - What else?
- Review and provide feedback on committee work
 - HITOC
 - Incentives and Outcomes (Payment Reform and Quality Metrics)
 - Workforce
 - Public Purchasers
- Additional input and next steps

October 1, 2010

Note: Agenda for second day will depend to some degree on feedback from first day of discussion. Current intent is to focus on reviewing the summary of the first day's discussion and making revisions as determined necessary.

****WORKING DOCUMENT****

VISION
Triple Aim for Oregon:



ABSTRACT

Project Title: Oregon Health Care Workforce Planning Project

Applicant Name: The Office for Oregon Health Policy and Research (OHPR) on behalf of the Oregon Workforce Investment Board (OWIB).

Address: 1225 Ferry Street SE, 1st Floor, Salem, OR 97301

Contact Phone No.: Lisa Angus, MPH, 503.373.1632 (phone) 503.378.5511 (fax)

Email Address: lisa.angus@state.or.us

Web Site Address: <http://www.worksourceoregon.org/index.php/state-workforce-board> and <http://www.oregon.gov/OHPPR/index.shtml>

The Oregon Workforce Investment Board (OWIB), in partnership with the Oregon Health Policy Board and its Health Care Workforce Committee, proposes a planning project to develop a strategic and comprehensive health care workforce development strategy for the state. Leveraging and expanding on existing efforts, the project will maximize Oregon's ability meet its current and future health care workforce needs.

The OWIB has partnered with the Oregon Health Policy Board in naming the Oregon Health Care Workforce Committee (Committee) the designated statewide planning partnership for this grant opportunity. Created by the Oregon Legislature in 2009 to coordinate state efforts to educate, recruit, and retain a quality workforce that will meet the demand for health care created by expansion in health care coverage, system transformation and an increasingly aging and diverse population, the Committee is the ideal partnership to achieve the project goals. The Oregon Health Care Workforce Development Planning Project will expand and accelerate the Committee's work by adding a dedicated coordinator into the existing staff infrastructure, leveraging existing resources and partnerships, and providing resources for more in-depth and sophisticated health care workforce data collection and analyses. These efforts will inform the creation of a comprehensive strategic plan with a vision for the needs of a redesigned health care system.

Over the past few years, Oregon has intensified its efforts to increase the quality and quantity of its health care workforce as an essential element of its comprehensive health care reform strategy. This HRSA grant funding would address the coordination of multiple health care workforce efforts occurring in the state and would extend and enhance opportunities for addressing urgent workforce shortages within an abbreviated time period. The outcome of this project—a comprehensive statewide strategic plan with an emphasis on primary care—will provide Oregon with a clear direction and a set of concrete actions for building its health care workforce and will set the stage for Oregon to obtain and leverage additional financial resources to implement its workforce development strategies.

**OHPB Incentives and Outcomes Committee
Draft Payment Reform Subcommittee Key Recommendations**

(Note: **Shaded material** has not been discussed by subcommittee as of 9/14; represent OHPR staff proposed ideas on implementation for discussion at 9/22 full committee meeting)

Summary:

Phase I (2010-2012)

- Build provider capacity to organize and deliver care more effectively and efficiently
- Standardize payment methods
- Align payment methods with Medicare
- Pilot new payment methodologies

Phase II (2012-2015)

- Standardize episode design
- Improve tools for setting cost and price targets that are reasonable but require the delivery system to become more efficient

Phase III (2015-2018)

- Migrate toward paying facilities and professionals using a method that drives spending toward efficient care at a cost the community can afford (Global budgets?)

Phase I (rollout begins 2010)

Payment Standardization

- What: Payment method must be the Medicare payment method (with rates negotiated in provider agreements and more comprehensive payment bundles permitted)
- Which services: Inpatient hospital, outpatient hospital, ambulatory surgery, physician and professional services
- Which providers/facilities: Prospective payment system hospitals (not critical access hospitals or type A and B hospitals), ambulatory surgery centers, physicians and other professionals paid according to Medicare RBRVS
- When:

- Hospitals and ASCs - October 1, 2012 (The date Medicare annual changes take effect)¹
- Physician and professional services - to be determined within three months by OHPR work group process
- How: New statutory requirement

Alignment with Medicare

- What:
 - Medicare policy not to pay prospective payment system hospitals for additional services required as a result of “never events” (hospital acquired conditions) applies to physician services also.
 - Pay-for-performance measures aligned to Medicare metrics, where Medicare has adopted one (for detail see “Pay for Performance Pilots”)
- **When: October 1, 2011**
- How:
 - OHA should include in payer and provider contracts
 - **Query: Should this be included in statutory standardization?**

Pay for Performance Pilots

- What: Payers should move toward allocating a portion of provider (professional and facility) fee for service payment amounts to pay for improving performance or meeting benchmarks on aligned metrics; pilots should be evaluated; and performance should be publicly reported.
- How:
 - OHA identifies metrics and benchmarks to be used in pay for performance programs and recommends percentage of payment to be allocated to p4p
 - Other payers align voluntarily
- When:
 - OHA to identify metrics, benchmarks, and recommended allocation to p4p by **October 1, 2011**
 - **OHA to include pilots in plan contracts by October 1, 2011**
- Points of disagreement: Some provider members of committee advocated requiring all payers to pay for performance in the same way, using the same metrics, while payers wished flexibility; a compromise might require payers to limit p4p metrics to those identified by OHA.

Episode Payment Pilots

- What: Payers should experiment with episode selection (including both chronic and Geisinger-style acute care bundles), design, and payment method; pilots should be evaluated; and performance should be publicly reported.
- How: Pilots may be conducted by OHA or other individual payers or on a multi-payer basis
- When:
 - **OHA to begin including in plan and provider contracts by October 1, 2011**

¹Flagged issue: Can non-federal payers immediately implement the Medicare payment system that takes effect October 1 of each year or is a 3-month or 1-year lag time required after publication of the final Medicare rules needed?

- Other payers should begin pilots ASAP

Service Agreements

- What: Providers, especially primary and specialty care practices, should enter into agreements specifying responsibilities for components of care
- How:
 - Build into primary care home at Tier 1
 - Experiment with requiring for participation in episode pilots
 - Experiment with paying specialty physicians for non-office visit, non-procedural services performed under service agreements such as reviewing records prior to referral, answering primary care provider questions, etc.
- When:
 - OHA builds into patient centered primary care home standards by January 1, 2011. [Dates not discussed in subcommittee.]
 - OHA, provider groups, and payer groups develop model service agreements for review by the Incentives & Outcomes Committee no later than July 1, 2011.

Patient Engagement²

- What: Providers should take more explicit responsibility for patient engagement and activation, including involving patients in self-management, shared decision-making, and delivery system transformation planning
- How:
 - Patient centered primary care home standards include patient engagement in standards
 - Service agreements include responsibility for patient engagement
- When:
 - OHA includes patient experience, shared decision-making responsibilities shared decision-making in primary care home standards announced by January 1, 2011.

Primary Care Home Pilots

- What: Pilot primary care home base payment for providing for a bundle of primary care infrastructure improvements and medical services; pilots should be evaluated; and performance should be publicly reported.
 - There are three tiers measuring progress toward more robust primary care home (Tier 1 – 2 – 3)
 - Provider contracts establish the amount of base payment at each tier that will be paid by particular payers.
 - Pay-for-performance and bundled payment shares may be wrapped into a larger base payment as lessons are learned from early implementation efforts and as primary care home become more robust
- How:
 - OHA adopts primary care home standards in three tiers.
 - OHA begins contractually requiring its carriers to implement primary care homes using proposed payment methodology, beginning with focused

² Formerly called “Shared Decision-Making.”

regional efforts where the OHA may be the predominant carrier for a given clinic.

- OHA develops plan to leverage CMS 90/10 match for Medicaid pilots using the primary care home tier framework.
- OHA reviews the prospective payment approach currently used by the safety net to ensure that it is sufficiently aligned with the proposed transitional payment system and augments payment proposal, if necessary, to ensure full participation by Safety Net providers.
- OHA develops statewide and regional learning collaboratives.
- When:
 - OHA to develop tiers by January 1, 2011
 - OHA to begin including in plan and provider contracts by October 1, 2011 (for 2012 plan year)
 - OHA to submit State Plan Amendment for CMS 90/10 January 1, 2011
 - OHA augments payment proposal, if necessary, for safety net participation no later than January 1, 2012
 - OHA establishes learning collaboratives no later than January 1, 2012
 - Other payers begin ASAP

Evaluation Generally

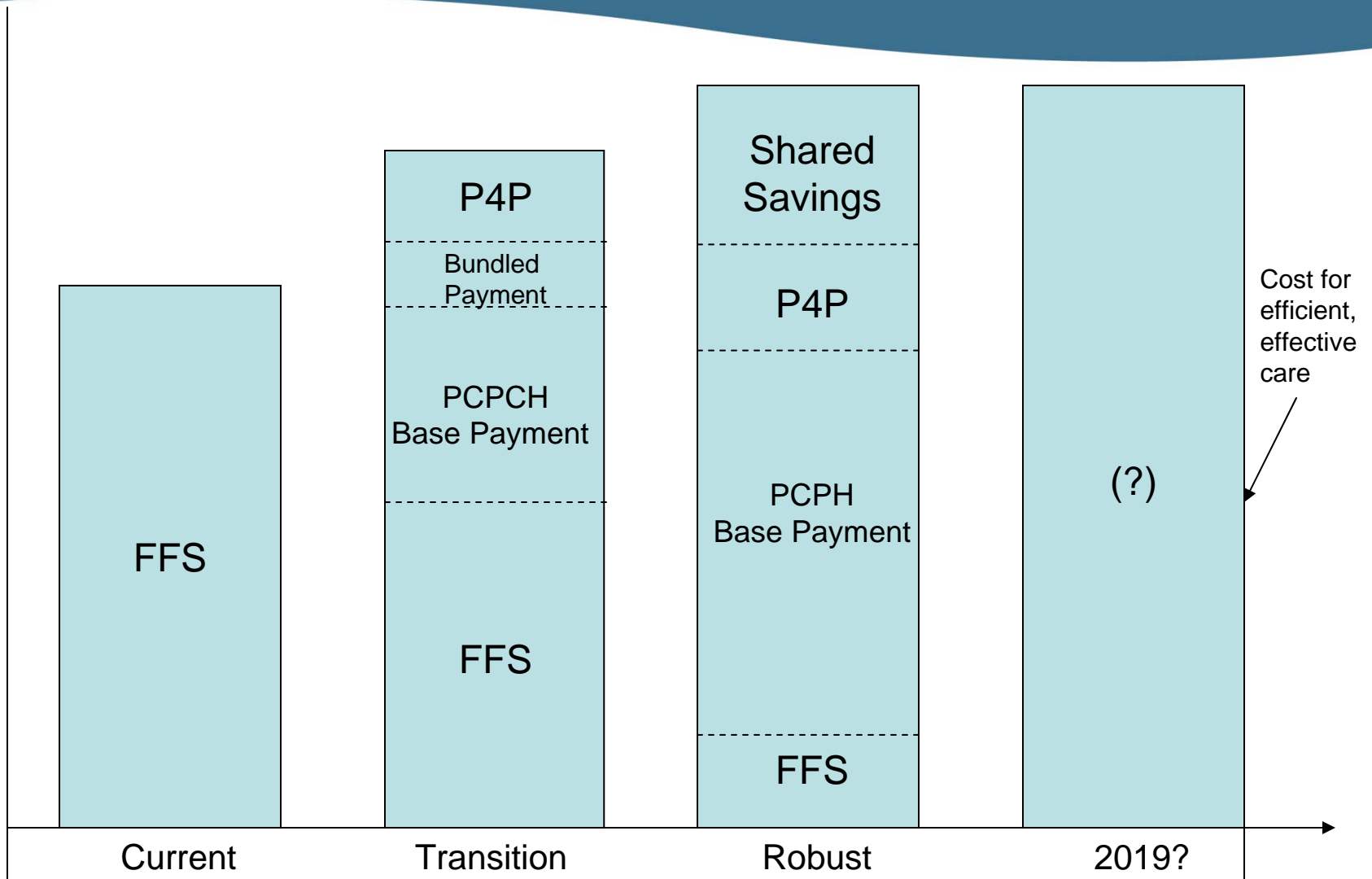
- What: All recommendations for pilots call for evaluation and transparency of provider performance.
- How: A single entity should be identified to develop an evaluation methodology, collect data, and report. (Q-Corp, OHA?)

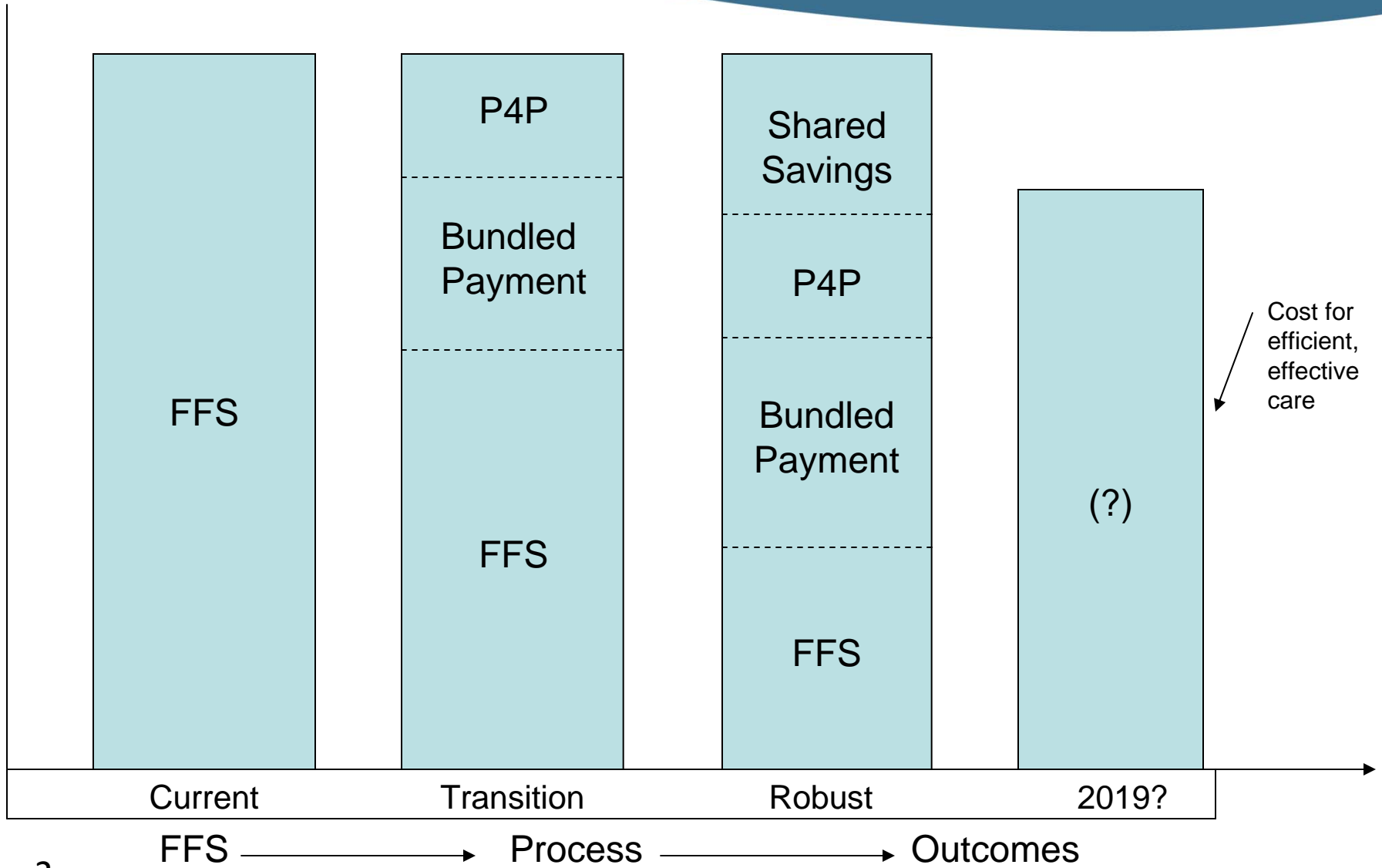
Provider Transformation Path

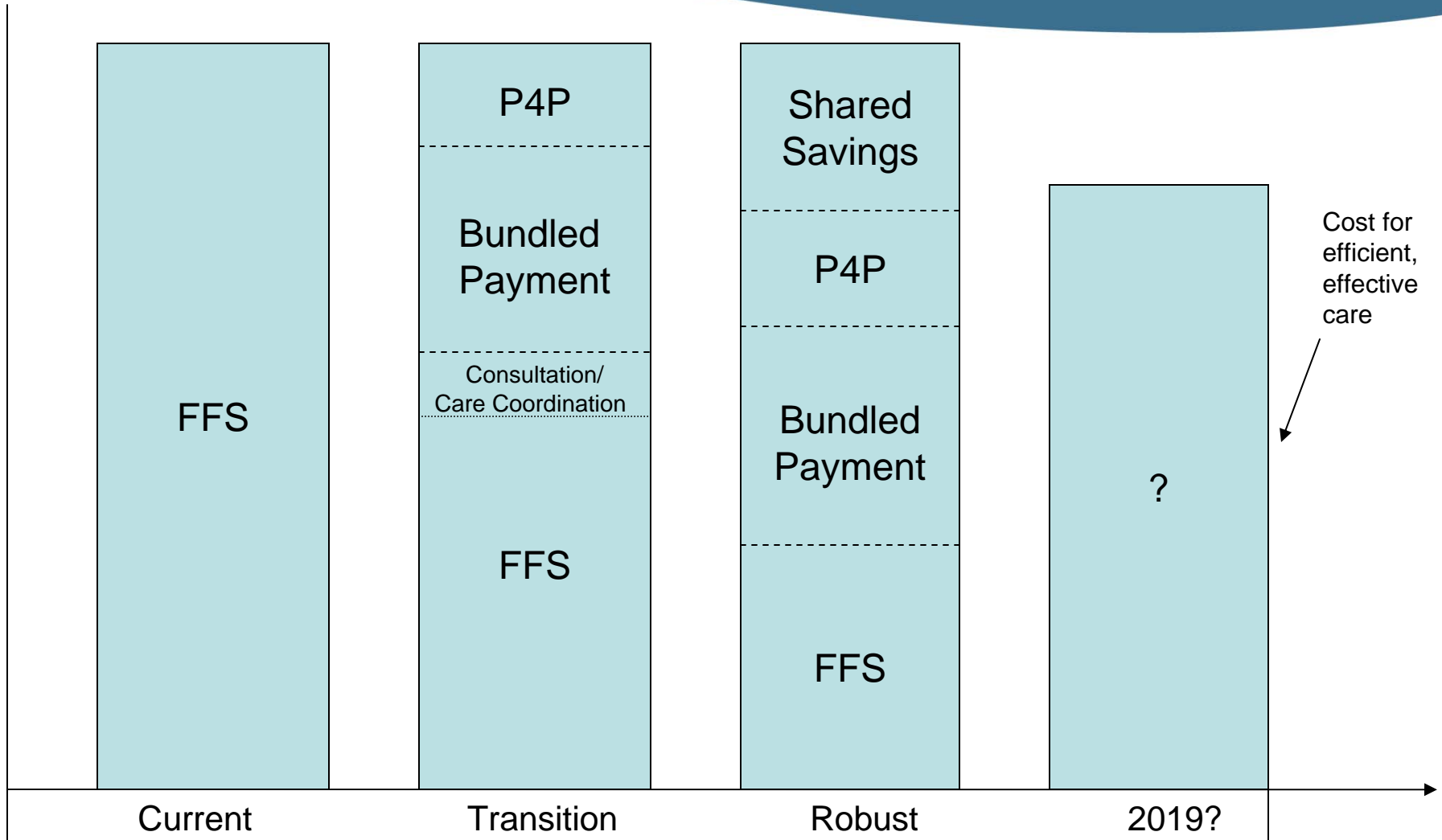
(See accompanying slides.)

Draft – For Discussion Only

Primary Care Payment Transition







Potential focus areas for Incentives & Outcomes Committee Proposals

The Incentives and Outcomes Committee believes that the health care system must do better in delivering care that is patient- and family-centered, effective, efficient, safe, timely, and equitable. Subcommittee work and staff research have generated a large number of clinical conditions or procedures that might serve as concrete starting points for pilot testing or initial roll-out of reforms designed to achieve those goals. This document outlines some of the similarities and differences between potential targets and is intended as an informational tool to assist in the identification of a small number of focus areas for reform proposals emerging from the full Committee.

The **Quality & Efficiency Subcommittee** has recommended targets that align with those identified by the National Priorities Partnership as having “the most potential to result in substantial improvements in health and health care, and thus accelerate fundamental change in our healthcare delivery system”.

The **Payment Reform Subcommittee** has identified the following as principles for payment system design: equity; accountability; transformative; cost containment; simplicity; and transparency. Its specialty workgroup has recommended targets based on evidence of variation, high cost, and potential for savings.

OHPR staff has recommended targets that rank high on at least 2 of the following dimensions:

- Potential to improve quality and efficiency where resource use is high or number of people affected is large (impact);
- Feasible to start addressing in the short-term (feasibility);
- Of differential importance to marginalized populations (health equity); and
- Potential for synergy with local or national partner efforts (synergy)

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Heart attack, heart failure (hospital setting – from CMS core measures)</p> <p><u>Rationale:</u> National alignment; existing reporting infrastructure</p>	<p>Cardiac conditions</p> <p><u>Rationale:</u> Key cost driver in commercial coverage</p>	<p>Congestive Heart Failure, Coronary Artery Disease</p> <p><u>Rationale:</u></p> <p>Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; OR commercial inpatient costs are highly variable</p> <p>Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are underutilized;</p> <p>Equity - disparities exist in receipt of recommended tx;</p> <p>Synergy - synergy with local or national partners;</p>

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<p>Low back pain / spine surgery appropriateness <u>Rationale:</u> NPP and local priority; high cost for PEBB; potential for useful physician profiling and intervention; good area for consumer education and shared decision-making.</p> <p>Joint replacement <u>Rationale:</u> NPP priority</p>	<p>Musculoskeletal conditions <u>Rationale:</u> Key cost driver in commercial coverage</p>	<p>prevalent chronic diseases</p> <p>Low back pain/surgery <u>Rationale:</u> Impact - High cost for PEBB; OR Medicare utilization high and variability within Oregon is high Feasibility - bundle models for episode payment exist; good patient decision-making tools exist Synergy - synergy with local and national partners</p> <p>Osteoarthritis and arthropathies/joint disorders and joint replacement <u>Rationale:</u> Impact: preventable complications are high % of commercial claims; cost driver in Medicare FFS and Oregon Medicare FFS cost is high; represents large share of hospital costs for commercial pop; Oregon Medicare utilization is high; commercial cost highly variable; Feasibility: bundle models for episode payment exist; high-value services are underutilized; Synergy - synergy with local and national partners</p>
	<p>Oncology <u>Rationale:</u> Key cost driver in commercial coverage</p>	<p>Colon cancer <u>Rationale:</u> Impact: preventable complications are high % of commercial claims; Oregon Medicare FFS cost is high Feasibility: bundle models for episode payment exist; good patient decision-making tools exist Equity: racial disparities exist in screening and mortality</p>
<p>Imaging appropriateness <u>Rationale:</u> NPP priority; national and local momentum; potential to address in inpatient and ED settings</p> <p>Cardiac diagnostics</p>	<p>Duplicate or inappropriate diagnostic tests</p>	

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
<u>Rationale:</u> NPP priority		
Skin injuries and falls (hospital setting) <u>Rationale:</u> NPP priority		
Readmissions (hospital setting) <u>Rationale:</u> measure of defects in coordination of care; cross-setting issue	Readmissions (hospital setting)	
Healthcare acquired infections <u>Rationale:</u> NPP priority; national and state momentum; opportunity to further NSQIP; existing state reporting infrastructure	Healthcare acquired infections	
		COPD <u>Rationale:</u> Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; Synergy - synergy with local or national partners; prevalent chronic disease
Maternity care (c-sections) <u>Rationale:</u> Difficult issue but huge area for Medicaid; good area for patient-centered and shared-decision making approaches; NPP priority	Maternity care	Pregnancy, delivery, newborns <u>Rationale:</u> Impact - High cost for OHP, PEBB; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available; high-value services are under-utilized; Equity - disparities exist by insurance status
Pneumonia (hospital setting – from CMS core measures) <u>Rationale:</u> National alignment; existing reporting infrastructure		Pneumonia <u>Rationale:</u> Impact - preventable complications are high % of commercial claims; high rate of readmissions; Oregon Medicare FFS cost is high; high cost for OHP; OR inpatient costs are highly variable; Feasibility - high-value services are under-utilized;

Quality & Efficiency Subcommittee	Payment Reform Subcommittee	Staff
		bundle models for episode payment exist Equity - disparities exist by income and insurance status Synergy - Synergy with national partners
Heart attack, heart failure (hospital setting – from CMS core measures) <u>Rationale:</u> National alignment; existing reporting infrastructure		
Children’s asthma care (hospital setting – from CMS core measures) <u>Rationale:</u> National alignment; existing reporting infrastructure		Asthma <u>Rationale:</u> Impact - preventable complications are high % of commercial claims Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Disparities - income-based disparities exist Synergy - synergy with local or national partners; prevalent chronic disease
		Diabetes <u>Rationale:</u> Impact - preventable complications are high % of commercial claims; high rate of readmissions; Feasibility - bundle models for episode payment exist; inexpensive, effective screening or tx available Equity - disparities exist particularly in complication rates Synergy - prevalent chronic disease
		Mental disorders (undifferentiated) <u>Rationale:</u> Impact - cost driver for Medicare; high cost for OHP, PEBB Disparities - OR suicide rate is high compared to nat’l average

OREGON HEALTH CARE WORKFORCE COMMITTEE
DRAFT Strategic Priorities and Short-Term Goals
August 2010

Established by House Bill 2009, Section 7 (3)(a), the Health Care Workforce Committee is chartered to coordinate efforts in Oregon to meet the demand for health care created by the expansion in health care coverage, system transformation and an increasingly diverse population. The Health Care Workforce Committee's role is to advise and develop recommendations and action plans for the Oregon Health Policy Board to guide efforts to train, recruit and retain a changing health care workforce to meet the needs of new systems of care.

Guided by Oregon's Triple Aim¹, the Committee recognizes the following principles for its work:

1. Build on collaborative and innovative partnerships within and across sectors (education, industry, government);
2. Value diversity in students, faculty and the workforce;
3. Maximize the efficient use of existing and future resources and pursue federal and other non-state funding opportunities that align with the Committee's priorities;
4. Promote the continuation and expansion of successful health profession education initiatives.

The Committee has identified these priorities to build and transform Oregon's health care workforce:

PRIORITY 1: Prepare current and future health care professionals to support system transformation via emerging models of integrated, team-based care delivery (e.g. primary care homes).

Understand the workforce-related implications of delivery system redesign:

- Identify the functions, roles, skills, expertise, and knowledge needed to work in inter-professional teams and for effective care management/coordination.
- Inform the development of curricula for inter-professional training and care management and use of technology.
- Create market conditions for the health system to respond to transformation through appropriate reimbursement strategies.

PRIORITY 2: Build the size and capacity of the health care workforce, particularly primary care, to help meet the anticipated increase in demand for health care services.

Revitalize the state's primary care practitioner loan repayment program.

Explore interests in and barriers to cooperative health care professional recruitment efforts for Oregon's rural and underserved communities to make the best use of finite resources

Increase primary care training capacity for current and future health care workforce.

PRIORITY 3: Strengthen the health care workforce pipeline to ensure that Oregon has enough health care workers with the right training in the right places.

Maintain funding for health professions education programs despite state budget cuts.

Create a favorable policy and regulatory environment for the expansion of healthcare professional training and placement and the development new of new training models. Initial actions include:

- Remove or revise the state's adverse impact policy and detrimental duplication process when developing new health care education programs.
- Minimize delays for qualified health professionals from other states applying for Oregon licensure.
- Reduce liability risk for students' clinical training in the work environment.
- Aggregate student background check functions.

¹ Oregon's triple aim is to: (1) improve the health of all Oregonians; (2) Increase the quality, reliability, and availability of care; and (3) Reduce or control the cost of care so that it is affordable to everyone.

- Standardize contractual relationships related to clinical placements between education and clinical training sites.

DRAFT

Overview of Selected Provisions in Federal Health Reform¹

Coverage and Access	
Individual Mandate	<ul style="list-style-type: none"> • Requires U.S. citizens and legal residents to have qualifying health coverage. <ul style="list-style-type: none"> — Those without coverage pay a tax penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. <ul style="list-style-type: none"> ○ After 2016, the penalty will be increased annually by the cost-of-living adjustment. • Exceptions given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold (\$9,350 for an individual and \$18,700 for a married couple in 2009). • <i>Secs. 1501. and 5000A.</i>
Medicaid Expansion	<ul style="list-style-type: none"> • Beginning 1/1/2014, expands Medicaid to all individuals under age 65 with incomes up to 133% FPL based on modified adjusted gross income. As under current law, undocumented immigrants are not eligible for Medicaid. <ul style="list-style-type: none"> — 100% federal match for “newly eligible” through 2016 <ul style="list-style-type: none"> ○ Phases down to 90% federal match in 2020 and after • Beginning 4/1/2010, states have the option to expand Medicaid eligibility to childless adults, but will receive their regular (unenhanced) FMAP until 2014. • Eliminates cost-sharing for preventive services in Medicaid and Medicare. Provides a one percentage point increase in the FMAP for these services. • Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing. • <i>Secs. 2001. through 2007.</i>
Health Insurance Exchange	<ul style="list-style-type: none"> • Creates regulated, consumer-oriented state-based health insurance marketplaces – or exchanges – through which individuals and small businesses with up to 100 employees can purchase coverage. <ul style="list-style-type: none"> — Businesses with > 100 employees permitted to purchase coverage in the Exchange beginning in 2017. • Exchanges will be operational in 2014. • Exchange tax credits and cost sharing subsidies; 100% federally funded <ul style="list-style-type: none"> — Premium tax credits available 133-400% FPL <ul style="list-style-type: none"> ○ People contribute to premiums on sliding scale ○ Not eligible for tax credits if offered employer coverage premium costs less than 8% of income — Cost-sharing subsidies 133-250% FPL <ul style="list-style-type: none"> ○ Reduces out-of-pocket costs at point of service • Requires Exchange plans to: <ul style="list-style-type: none"> — Pay FQHCs a rate no less than their Medicaid PPS rates. — Contract with all safety net providers or “essential community providers”—defined in the new law as those eligible to participate in the 340B drug discount program. • <i>Secs. 1301. through 1304.</i> • In Oregon over 360,000 Oregonians could take advantage of the Insurance Exchange.
Changes to Private Insurance	<ul style="list-style-type: none"> • Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud. <i>Secs. 2711. through 2712.</i>

¹ [Patient Protection and Affordability Act of 2010 \(P.L. 111-148\) and the Health Care and Education Reconciliation Act of 2010 \(P.L. 111-152\).](#)

Coverage and Access	
	<ul style="list-style-type: none"> • Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force, the CDC, and HRSA, without any cost-sharing. <i>Sec. 2713.</i> • Young adults will be allowed to remain on their parent's health insurance up to age 26. <i>Sec. 2714.</i> • Waiting periods for coverage will be limited to 90 days. <i>Secs. 2708. and 10103.</i>
Federal Requirements on Large (50+ FTE) Employers	<ul style="list-style-type: none"> • Expected to provide coverage to full-time workers (30+ hours/week). Penalty is triggered if any full-time employee of employer qualifies for an individual tax credit or cost-sharing through the Exchange. • Employers with 50 or fewer employees will be exempt from any penalties. • <i>Sec. 1513.</i>
Federal Small Employer Tax Credit	<ul style="list-style-type: none"> • Employer must pay at least half of premium • Credit is percentage of employer's contribution <ul style="list-style-type: none"> – Maximum credit = 10 or fewer FTEs AND average FTE wages of \$25,000 or less. – No credit with 25 or more FTEs OR average FTE wages of \$50,000 or more • For 2010-2013, max 35% credit available for any small employer meeting conditions • Effective 2014, max 50% credit available only if employer buys coverage through Exchange. • <i>Secs. 1421. and 45R.</i>
High Risk Pool	<ul style="list-style-type: none"> • U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in a temporary national high-risk pool and receive subsidized premiums. • Appropriate \$5B to finance the program. (Effective within 90 days of enactment until 1/1/2014.) • <i>Sec. 1101.</i> • OHA launched a federally funded high risk pool in mid-July. The new insurance pool adds another option for uninsured Oregonians with existing medical conditions to purchase health insurance, in addition to the existing OMIP.
Reinsurance Program	<ul style="list-style-type: none"> • Beginning June 2010 through 1/1/14, a temporary reinsurance will be available to employers providing health benefits to early retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. Appropriate \$5B to finance the program. • <i>Sec. 1102.</i>
Behavioral Health	<ul style="list-style-type: none"> • Grants for co-location of primary and specialty care in community-based mental health setting, \$50M available nationally beginning in 2010. • <i>Sec. 5604.</i>
Funding for Federally Qualified Health Centers (FQHCs)	<ul style="list-style-type: none"> • Authorizes the following appropriations: FY2010 - \$2.98B; FY2011 - \$3.86B; FY2012 - \$4.99B; FY 2013 - \$6.44B; FY2014 - \$7.33B; FY2015 - \$8.33B. • Specifies CHCs can contract with rural clinics, critical access hospitals, and sole community hospitals for delivery of primary care services if they use a sliding scale for low-income pts. • <i>Sec. 5601.</i>
Community Health Centers (CHCs) Program Funding	<ul style="list-style-type: none"> • Establishes CHC Fund for enhanced funding for CHCs and the National Health Service Corps; \$11B over five years (FY 2011-FY 2015); \$1.5B for construction and renovation of CHCs. • <i>Sec. 10503 as modified by Sec. 2303. of P.L. 111-152</i>

Coverage and Access

Funding for School Based Health Centers (SBHCs)	<ul style="list-style-type: none"> • Targets high needs areas and gives preference to sites serving high Medicaid/CHIP population • Separate grants for establishment and operation of SBHCs • Appropriates \$50M per year (FYs 2010-2013) for establishment grants and authorizes such funds as necessary (FYs 2010-2014) for operating grants (20 percent non-federal match requirement) • <i>Sec. 4101; Sec. 10402 adds vision services to the list of health services for which a SBHC should provide referrals.</i>
HPSA/MUA Shortage Designation Guidelines	<ul style="list-style-type: none"> • Establishes a process of “negotiated rulemaking” between HHS and stakeholders to determine new criteria and methodology for defining Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) measurements. • <i>Sec. 5602.</i>
Demo. Project to Provide Access to Affordable Care	<ul style="list-style-type: none"> • Demo through HRSA to provide access to comprehensive health care services to the uninsured at reduced fees. • Grants in up to 10 states, to carry-out the project for a 3-year demonstration period; total funds up to \$20M. • <i>Sec. 10504.</i>
<p>Coverage Estimates of Federal Reform in Oregon (conducted by Jonathan Gruber for the Oregon Health Authority, 2010)</p> <ul style="list-style-type: none"> • Coverage Status Under Federal Reform by 2019 <ul style="list-style-type: none"> – Medicaid (OHP): 560,000 – Exchange: 360,000 – Individual: 130,000 – Group (Employer): 2,080,000 – Uninsured: 290,000 – Total * 3,420,000 • 65% of the uninsured obtain coverage by 2019 <ul style="list-style-type: none"> – The remaining uninsured <ul style="list-style-type: none"> ○ Over 50% are under age 35 ○ Over 50% are under 200% FPL ○ Over 70% are in Urban areas 	

Delivery System Transformation	
Overall Improvement	<ul style="list-style-type: none"> • HHS to develop national quality improvement strategy. <i>Secs. 3011. through 3015.</i> • Establishes federal CMS Innovation Center to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. <i>Sec. 3021.</i> • Grants or contracts to establish community health teams to support the patient-centered medical home. <i>Secs. 3502 and 10321.</i>
Improvements in Medicaid	<p>Quality standards – accountability, measurement and reporting:</p> <ul style="list-style-type: none"> • HHS to develop a set of quality measures for Medicaid eligible adults (similar to the quality measurement program for children enacted in the Children’s Health Insurance Program Reauthorization Act of 2009). • <i>Sec. 2701.</i> <p>Medicaid payment reform pilots:</p> <ul style="list-style-type: none"> • State option to provide health homes for enrollees with chronic conditions. Begins 1/1/2011; total amount of payments made to states is \$25M. <i>Sec. 2703.</i> • Demonstration project to evaluate integrated care around a hospitalization. Demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid. <i>Sec. 2704.</i> • Medicaid global payment system demonstration project. Demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure. <i>Sec. 2705.</i> • Pediatric Accountable Care Organization demonstration project. Allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings. <i>Sec. 2706.</i> <p>Other payment reform in Medicaid:</p> <ul style="list-style-type: none"> • Improving access to preventive services for eligible adults in Medicaid. States electing to cover these approved additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased FMAP of one percentage point for these services. <i>Sec. 4106.</i> • Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid. <i>Sec. 4107.</i> • Incentives for prevention of chronic diseases in Medicaid. <i>Sec. 4108.</i>
Improvements in Medicare	<p>Value-based purchasing (VBP) in Medicare</p> <ul style="list-style-type: none"> • Value-based incentive payment to hospitals beginning with discharges in FY2013. <i>Sec. 3001 & 10335.</i> • Plans for a VBP program for skilled nursing facilities, home health agencies and ambulatory surgical centers. Plan due to Congress by FY2012. <i>Secs. 3006 and 10301.</i> • Value-based adjustment for physician fee schedule developed by 2012; implemented 2015-17. <i>Sec. 3007.</i> <p>Quality standards – accountability, measurement and reporting:</p> <ul style="list-style-type: none"> • Improvements to the physician quality reporting initiative. Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. <i>Secs. 3002. and 10327.</i> • Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals and hospice programs. Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY2014. <i>Sec. 3004.</i>

Delivery System Transformation

	<ul style="list-style-type: none"> • Medicare will reduce payments to hospitals in top quartile of infection rates by 1% beginning 2015. Future expansions possible. <i>Sec. 3008.</i> <p>Medicare payment reform pilots:</p> <ul style="list-style-type: none"> • Medicare Accountable Care Organization pilots. Begins 1/1/2012 for 3 years; 5,000 beneficiary minimum. <i>Secs. 3022 and 10307.</i> • Bundled payments for acute and post-acute care on 8 conditions, with shared savings. Begins 1/1/2013 for 5 years; expand in 2016 if successful. <i>Secs. 3023 and 10308.</i> • Independence at home demonstration program for high-needs patients. <i>Sec. 3024.</i> • Hospital readmissions reduction program. Beginning in FY2012, based on percent of preventable readmissions; future expansions possible. <i>Secs. 3025 and 10309.</i> • Community-based care transitions program. Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. Begins January 1, 2011, funding for a five-year period; \$500M total available. <i>Sec. 3026.</i> • Extension of Deficit Reduction Act hospital quality gainsharing demonstration. Demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. Extends demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. It would also authorize an additional \$1.6M in FY2010 for carrying out the demonstration. <i>Sec. 3027.</i> <p>Medicare Reimbursement for FQHCs:</p> <ul style="list-style-type: none"> • Removal of barriers to preventive services in Medicare. FQHC preventive services updated to include an expanded list of preventive services covered under Medicare, effective for services provided on or after 1/1/2011. <i>Secs. 4104. and 10406.</i> • FQHCs' Medicare reimbursement will be updated to a new prospective payment system (PPS) effective on or after October 2014. At this time, both the Medicare cap and productivity screen are eliminated. <i>Sec. 5502.</i>
Expanded Participation in 340B Program	<ul style="list-style-type: none"> • Extends participation in the 340B program to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers, and exempts orphan drugs from required discounts for new 340B entities. • <i>Sec. 7101.</i>
Behavioral Health Integration	<ul style="list-style-type: none"> • Authorizes Medicaid reimbursement for emergency stabilization services (under EMTALA) in private mental health facilities – number of awards not stated, 2010-15.
Dental Health	<ul style="list-style-type: none"> • Alternative dental health care provider demonstration project. \$4M; 2012-2017. • <i>Sec. 5304.</i>
Community-based Collaborative Care Networks	<ul style="list-style-type: none"> • Grants to develop networks of providers to deliver coordinated care to low-income populations. Authorizes such sums as necessary for FYs 2011 through 2015. • <i>Sec. 10333.</i>

Workforce	
State Health Care Workforce Development Grants	<ul style="list-style-type: none"> • FY 2010; awarded for a period of one year with a maximum award of \$150,000 per grant. • <i>Sec. 5102.</i> • Oregon has submitted an application for this grant, which aims to leverage and expand on existing efforts, to maximize Oregon's ability meet its current and future health care workforce needs.
Primary Care	
National Health Services Corp	<ul style="list-style-type: none"> • Increases authorized funding from \$320M in FY2010 to \$1.15B in FY2015, and authorizes out-year increases commensurate to the percentage increase in Health Professionals Shortage Areas (HPSAs) and the cost of health professions education. • <i>Sec. 5207.</i> • New CHC Fund with mandatory funding for NHSC over the FY2008 appropriated level (\$124M), from \$290M in FY2011 to \$310M in FY2015 • <i>Sec. 10503.</i> Allows for half-time service waivers under two different scenarios: <ul style="list-style-type: none"> – Double the period of service – Receive 50% of amount otherwise payable • Increases the annual loan repayment award maximum from \$35,000 to \$50,000, including possible inflationary increases starting in FY2012 • Teaching can count for up to 20% of the NHSC clinical practice service obligation and teaching under the new "teaching health center graduate medical education program" can count for up to 50% of the NHSC clinical practice service obligation • <i>Sec. 5508. as amended by Sec. 10501.</i>
Primary Care Extension Program	<ul style="list-style-type: none"> • Establishes a primary care extension program through AHRQ which provides grants to establish "State Hubs" and local extension agencies to support local primary care physicians with the implementation of medical home, evidence based medicine, and improved community health. • Authorized \$120M/yr for FY11 and FY12, and such sums as necessary FY13 and 14; grantees must develop a plan for financial sustainability once Federal funding decreases (after initial 6-year period). • <i>Sec. 5405.</i>
Grants to Develop/Expand Primary Care Residency Programs	<ul style="list-style-type: none"> • Priority for applicants that demonstrate the following: support programs that focus on the medical home innovative teaching methods; formal relationships with FQHCs, rural health clinics, or AHECs history of graduates in primary care or in underserved areas, among other items. • Awards for five years; authorizes \$125M for 2010 plus such sums as necessary through FY 2014 w/ 15% of funds allocated for PA programs; \$750K/yr for integrating academic administrative units • <i>Sec. 5301.</i>
Teaching Health Centers	<ul style="list-style-type: none"> • Establishes "Teaching Health Centers" (THCs) for training of primary care residents in CHCs and other settings • Authorizes \$25M for FY 2010; \$50M/yr for FY 2011 and FY 2012 then such sums as necessary • Also authorizes and appropriates such sums as necessary for direct and indirect costs of training residents up to \$230M for FYs 2011-2015 under Title III of the PHSA for payments to qualified THCs • <i>Sec. 5508.</i>

Rural Physician Training	<ul style="list-style-type: none"> • Amends Title VII to establish a grant program for medical schools to establish, improve, or expand “rural-focused” education and training meeting certain criteria, including recruiting students likely to practice in rural communities. • Authorizes \$4M per year FYs 2010-13; • <i>Sec. 10501(l).</i>
Other Health Workforce Provisions	
Area Health Education Centers (AHECs)	<ul style="list-style-type: none"> • Reauthorize the Title VII AHEC program with grants to maintain and improve existing AHECs • <i>Sec. 5403.</i>
Health Care Professionals Training for Diversity	<ul style="list-style-type: none"> • Reauthorizes Title VII Centers of Excellence, Scholarships for Disadvantaged Students, Health Careers Opportunity Program, and Faculty Loan Repayment Program; • Faculty Loan Repayment Program (FLRP): Increases max award to \$30k; • Scholarships for disadvantaged students: increases authorized funding • \$37M to \$51M in FY 2010; such sums as necessary thru 2015 • Health Careers Opportunity Program: authorizes \$60M in FY 2010 and such sums as necessary to FY 2014 • <i>Sec. 5402.</i>
Expanding Physician Assistants’ Role in Medicare	<ul style="list-style-type: none"> • Authorizes PAs working with physicians to order post-hospital extended care services. Effective 1/1/2011. • <i>Sec. 3108.</i>
Alternative Dental Providers in Rural/Underserved Areas	<ul style="list-style-type: none"> • 15 grants to programs that train, or employ, alternative dental health care providers in rural/underserved areas. Minimum \$4M per 5-year grant; authorizes such sums as necessary. • <i>Sec. 5304.</i>
Mental and Behavioral Health Education and Training	<ul style="list-style-type: none"> • Authorizes grants (FY 2010-13) to institutions to recruit students and support educational and clinical training in: Social Work (\$8M), Graduate psychology (\$12M), Child and Adolescent professional work (\$10M); Child and Adolescent paraprofessional work (\$5M). • <i>Sec. 5306.</i>
Demonstration Project to Provide Low Income Individuals with Support for Health Professions Training	<ul style="list-style-type: none"> • Grantees provide support to low-income individuals to enter health profession training in shortage fields and/or in high demand professions. • Also develops training and certification programs for home care aides in 6 states. • Appropriates \$85M/yr for FYs 2010-2014, \$5M/yr (FY 2010-2012) allocated for personal and home care aide demo. • <i>Sec. 5507.</i>
Tuition Assistance for Direct Care Workers	<ul style="list-style-type: none"> • Funding for training programs for tuition assistance for students • Individuals receiving the assistance must agree to practice in geriatrics, disability services, long term or chronic care mgmt for min of 2 yrs. • Authorizes \$10M for the period of FY 2011-2013 • <i>Sec. 5302.</i>

Health Equity	
Maternal, Infant, and Early Childhood Home Visiting Programs	<ul style="list-style-type: none"> • Maternal, Infant and Early Home Visiting Programs targeting at-risk communities. Grant program optional – Title V programs eligible entities but if states do not apply, can be opened up to NGO’s. Limited/Intermediate impact depending on structure. • <i>Sec. 2951.</i>
Patient Navigator Program	<ul style="list-style-type: none"> • Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients overcome barriers to health services. -- Assists community organizations in helping individuals receive better access to care, information on clinical trials, and conduct outreach to health disparity populations. • <i>Sec. 3510.</i>
Health Disparities Data Collection and Analysis in Federally Conducted or Supported Programs	<ul style="list-style-type: none"> • Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity. • The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant Federal agencies. • <i>Sec. 4302.</i>
Plain Language in the Exchange	<ul style="list-style-type: none"> • Requires plans in the state exchanges to submit information in “plain language” including language that can be readily understood by individuals with limited English proficiency. Intermediate/High impact on safety net population over time. • <i>Sec. 10104.</i>
Office of Minority Health	<ul style="list-style-type: none"> • Establishes Office of Minority Health including individual offices within seven HHS agencies. • The Offices of Minority Health will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. Limited impact that could build over time depending on effectiveness. • <i>Sec. 10334.</i>