

OREGON HEALTH FUND BOARD

October 30, 2007
1:00pm (Digitally Recorded)

Kaiser Permanente Town Hall Ball Room
Portland, OR

- MEMBERS PRESENT:** William Thorndike, Jr., Chair
Jonathan Ater, Co-Vice Chair
Eileen Brady, Co-Vice Chair
Thomas Chamberlain
Charles Hofmann, M.D.
Raymond Miao
Marcus Mundy
- STAFF PRESENT:** Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Nora Leibowitz, Acting Director, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Brandon Repp, Research Analyst
Nate Hierlmaier, Policy Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst
- OTHERS PRESENT:** Ellen Lowe, Chair, Enrollment and Eligibility Committee
Senator Alan Bates
Senator Ben Westland
- ISSUES HEARD:**
- Call to Order/Introductions/Review & Approve Agenda
 - Coverage Trends in Oregon
 - State Health System Performance and Trends in Reform
 - Working Lunch: Executive Director Update, Committee bylaws, Appointments to Committees
 - Recommendations for Reform: Oregon Business Council, Oregon Health Policy Commission, Comment from Anne Gauthier
 - Organizational Issues: Planning Assumptions, Committee Charters, Time Line
 - Public Comments
 - Other Business

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

(Digitally Recorded)

- Chair Thorndike** **I. Call to Order/Introductions/Review & Approve Agenda**
- There was a quorum. The Board and staff introduced themselves to the audience.
 - Senator Bates addressed the Board.

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

- Dan Field, Vice President, Kaiser Permanente Northwest Region, provided book on Health Care Reform.

Jeanene Smith, MD II. Coverage Trends in Oregon (see Exhibit Materials 3).

Provided information on who has coverage in Oregon with breakdowns by Medicaid, employer-sponsored insurance, Medicare, Medicare Advantage and issues surrounding those who are not insured with discussion and comments by the Board.

Discussion

- Two income families who have two options for coverage.
- Correlations between group insurance enrollment, business and the economy.
- Aging populations and long-term projections.
- Board asked about documented and undocumented workers. Staff replied statistics are from Oregon Population telephone survey conducted every two years and probably is not a good indication of these individuals.

Presentation

III. State Health System Performance & Trends in Reform (see Exhibit Material 4 and 5)

Anne Gauthier, the Commonwealth Fund, provided a presentation on reform, research and "Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund."

- Oregon ranked 34th overall, 45th in access, 36th in quality and 48th in equity
- Discussion on migration as a result of health care reforms
- Discussion of indicators for ranking
- Comparisons with other states
- Delivery Reform
- Discussion on Medicare reimbursement
- Readmission impact on costs

The Commonwealth Fund will be coming out with recommendations in five areas, strategies to expand coverage, the Massachusetts Health Plan, the Federal Poverty Level (FPL) as a measurement and Maine's and other states' reform efforts.

Chair Thorndike

IV. Working Lunch

- Executive Director Update
 - Review of Timeline of SB 329
- Committee Bylaws
 - Review of Updated Committee Bylaws

Motion to approve committee bylaws is seconded. **Motion passed unanimously.**

- Appointments to Committees (see Exhibit Materials 12)

- o Reviewed recommendations of new committee members' appointments and transfers. Elected committee chairs and vice-chairs were identified.

Motion to approve list of committee members is seconded. **Motion passed unanimously.**

Presentations

V. Recommendations for Reform (see Exhibit Materials 7, 8 and 9)

- **Oregon Business Council** – Presentation by Peggy Fowler and Duncan Wyse followed by questions and discussion.
- **Oregon Health Policy Commission** – Presentation by Denise Honzel followed by questions and discussion.
- Anne Gauthier commented on recommendations.

Barney Speight

VI. Organizational Issues (see Exhibit Materials 14, 15 and 16)

- Planning Assumptions
- Committee Charters
- Timelines

Chair Thorndike

VII. Public Comments

Chris Demars, Oregon Health Reform Collaborative, presented testimony and submitted a memo from the Oregon Health Resources Commission (OHRC) to the Board.

Chair Thorndike

VIII. Other Business

Chair Thorndike

IX. Adjourn

Chair adjourns the meeting at approximately 4:05 p.m.

Next meeting November 6.

Submitted By:
Paula Hird

Reviewed By:

EXHIBIT MATERIALS

1. Speaker Bios
2. Federal Poverty Level Chart
3. Oregon 2006 Trends in Coverage Presentation Slides
4. Why Not the Best? A High Performance Health Care System for Oregon Presentation Slides
5. Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund*
6. State of the States, Robert Wood Johnson Foundation**
7. Matrix comparing OBC and OHPC reform recommendations***
8. Oregon Business Council Reform Recommendations Presentation Slides
9. Oregon Health Policy Commission Reform Recommendation Presentation Slides
10. Model Committee Bylaws
11. Committee Appointments and Transfers Memo
12. Revised Committee Rosters
13. Bios for Proposed Members of Health Equities Committee
14. OHFB Design Principles and Assumptions
15. Committee Charters
16. OHFB Timeline
17. Memo from Oregon Health Reform Collaborative

*http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

**<http://statecoverage.net/pdf/StateofStates2007.pdf>

***Oregon Business Plan Policy Playbook: Health Care available at:
<http://www.oregon.gov.DAS/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf>

DRAFT

OREGON HEALTH FUND BOARD

December 12, 2007
1:00pm (Digitally Recorded)

CCC, Wilsonville Training Center, Room 111-112
Portland, OR

MEMBERS PRESENT: Board

William Thorndike, Chair	Vanetta Abdellatif
Jonathan Ater, Co-Vice Chair	Tina Castanares, MD
Eileen Brady, Co-Vice Chair	Dave Ford
Thomas Chamberlain	Vickie Gates
Charles Hofmann, M.D.	William Humbert
Raymond Miao	Dale Johnson, Jr.
Marcus Mundy	Carolyn Kohn
	Diane Lovell
<u>Delivery</u>	Bart McMullan, Jr., MD
Dick Stenson, Chair	Stefan Ostrach
Maribeth Healey, Co-Vice Chair	Ken Provencher
Doug Walta, MD, Co-Vice Chair	Lillian Shirley, BSN
Richard Wopat, MD	Mike Shirtcliff, DMD
Mitch Anderson	Charlie Tragesser
Stefan Ostrach	

Anyone by phone?

OTHERS PRESENT: Ellen Lowe, Chair, Eligibility and Enrollment Committee
Ella Booth, Chair, Health Equities Committee
Senator Ben Westlund

STAFF PRESENT: Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Nora Leibowitz, Acting Director, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Introductions/Review and Approve Meeting Agenda
- Review and Approval of Revised Committee Charters and Design Principals and Assumptions
- Call Joint Meeting of Board and Delivery Systems Committee to Order
- Characteristics of a Patient-Centered Medical Home
- Panel: What are Oregon Health Insurers Doing to Promote Medical Homes? Dave Labby, CareOregon; Ralph Prows, Regence Blue Cross Blue Shield; and Thomas Hickey, Kaiser Permanente
- Presentation: Efforts to Unify Primary Care Providers around Medical Home Model, by Chuck Kylo, Greenfield Health, David Dorr, OHSU
- Invited Testimony and Public Testimony
- Other Business

(Digitally Recorded)

Chair Thorndike I. Call to order the meeting of the Oregon Health Fund Board/Review and Approve Meeting Agenda.

There is a quorum. Board, Committee Members and staff introduced themselves.

Chair Thorndike II. Review and Approval of Revised Committee Charters and Design Principals and Assumptions

Barney Speight overviewed "A Comprehensive Plan for Reform: Design Principals and Assumptions" as amended with previous suggestions from the Board incorporated.

- Concern regarding Assumption H as it appears to lock in the existing business model of employers funding much of the health care reform.

Motion to adopt the document, "A Comprehensive Plan for Reform: Design Principals and Assumptions" is seconded.

Discussion

- Agreement that Assumption H is too limited and suggests a program is being designed only for the uninsured, when it is a program for all Oregonians.
- Cost containment statement should be related not only to the health coverage for the uninsured but also to employer-based costs.
- Under Assumption A include the wording "cost containment" and more flexibility in H; and Assumption I regarding revenue should be changed to "new funding mechanisms."

The plan will be amended to add cost containment to Assumption A, change Assumption I to new funding mechanisms, and, in regards to the concern of Assumption H, a new Principal will be added stating that this plan not only looks at systems to bring the uninsured into coverage but also to reform the existing delivery system and financing system for those who have coverage.

The question is called for to approve the Comprehensive Plan as amended. Motion passed unanimously.

The Director will rework the document and send it out for comment.

Review and Approval of Revised Committee Charters presented by Barney Speight

- Four charters for consideration:
 - **Delivery System Committee**, highlighting changes made to:
 - Principals: efficiency, economic sustainability, use proven models, fund a high quality and transparent health care delivery system and ensuring costs do not exceed cost of living increases.
 - Scope concepts were highlighted, including adding to Public Health and Prevention and End-of-Life Care.
 - **Quality Institute Work Group**

- This group will look at the issue of information transparency. The Governor's office will probably form a Health Infrastructure Advisory Committee (HIAC) that will look at information and technology.
- Question regarding the Quality Institute and composition of group – doctors, health systems, insurers, providers, counselor, it was ask
- **Eligibility and Enrollment Committee** charter points were highlighted. Ellen Lowe, Chair of the Committee, responded to questions concerning the timeline for submitting reports and information that will be needed from the Benefits Committee to complete some reports.
- **Federal Laws Committee** charter was reviewed.

Motion to adopt the charters for the Delivery System, Eligibility and Enrollment, Quality Institute and the Federal Law Committees is seconded. **Motion passes unanimously.**

The Chair welcomed Senator Kurt Schrader who addressed the committees.

Dick Stenson

III. Call to order the Joint Meeting of the Board and the Delivery Systems Committee

Barney Speight reviewed meeting schedules and discussed finalizing arrangements with The Institute of Health Policy and Solutions, which has been working with Massachusetts and California on reforms, and James Matheson, an independent actuary, which has been working on the Boston Health Policy and Research, as consultants.

Representative Tina Kotek is welcomed.

Jeanene Smith, MD

IV. Characteristics of a Patient-Centered Medical Home

Presented a brief overview of The Medical Home Model of Primary Care (see exhibit materials).

- Definition of primary care includes general pediatrics, general internal medicine, family medicine and OB-GYN.
- Statistics from the Board of Medical Examiners states there are 3,964 primary care physicians, if you include all OB-GYN's.
- Background of primary care, integrating behavioral, mental and public health, and community collaborative activities.
- The importance of other key health care professionals, e.g. Nurse Practitioners.
- Emergency room use.

Presentations

V. Panel: What are Oregon Health Insurers Doing to Promote Medical Homes?

Panel Members David Libby, MD, PhD, CareOregon; Ralph Prows, MD, Regence Blue Cross Blue Shield; and Thomas Hickey, MD, Kaiser Permanente (see exhibit materials for copies of Power Point presentations).

Each panel member gave a presentation on medical homes including research and pilot programs.

Discussion

- Some topics discussed included:
 - Integrating care for individuals and families
 - Panel sizes and implementation of these type of models
 - Medical homes cost, cost methodology and administrative costs
 - Lack of primary care physicians
 - Chronic care
 - Customer focus
 - Health Information Technology
 - Primary Care Home collaboratives

Presentation

VI. Efforts to Unify Primary Care Providers around Medical Home Model

Presentations by David Dorr, MD, OHSU and Chuck Kilo, MD, Greenfield on the benefits and challenges of medical homes in primary care.

Bill Thorndike

VII. Invited Testimony and Public Testimony

The following were invited to provide testimony:

- Rick Wopat
- Mike Grady
- Craig Hostetler

Public testimony was given by:

- David Pollack, OHSU

Bill Thorndike

VIII. Other Business - None

**Bill Thorndike/
Dick Stenson**

IX. Adjourn

The meeting was adjourned at approximately 5:05 p.m.

The next meeting for the Oregon Health Fund Board will be January 15, 2008, at the Port of Portland Commission Room in Portland.

Submitted By:
Paula Hird

Reviewed By:

EXHIBIT SUMMARY

1. Agenda
2. Revised Committee Charters
3. Reform Design Principles and Assumptions
4. The Medical Home Model of Primary Care, Draft Report Prepared for Office for Oregon Health Policy and Research
5. Joint Principles of a Patient-Centered Medical Home, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, February 2007.
6. Beal A, et al., Closing the Divide: How Medical Homes Promote Equity in Health Care, The Commonwealth Fund, June 2007
7. Jeanene Smith Presentation Slides – Characteristics of a Patient-Centered Primary Care Home
8. Speaker Bios
9. Insurer Panel Materials
 - a. Ralph Prows Presentation Slides – Primary Care Home: Overview of Collaboration
 - b. Thomas Hickey Presentation Slides – Kaiser Permanente Vision
 - c. Goodson J, Unintended Consequences of Resource-Based Relative Value-Scaled Reimbursement, JAMA, November 2007, 298(19):2308-2319
 - d. David Labby Presentation Slides
10. Provider Panel Materials

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

- a. Summary of Better Health Initiates Meetings
- b. David Dorr Presentation Slides – Medical homes in primary care: policy implications from Care Management Plu

DRAFT

OREGON HEALTH FUND BOARD

January 15, 2008
11:30am (Digitally Recorded)

Port of Portland, Commission Room
Portland, OR

MEMBERS PRESENT: William Thorndike, Chair
Jonathan Ater, Co-Vice Chair
Eileen Brady, Co-Vice Chair
Thomas Chamberlain
Charles Hofmann, M.D.
Raymond Miao
Marcus Mundy

OTHERS PRESENT: Ellen Lowe, Chair, Eligibility and Enrollment Committee
Ella Booth, Chair, Health Equities Committee
Susan King, Chair, of the Benefits Committee
William Smith, OHPR

STAFF PRESENT: Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Nora Leibowitz, Acting Director, Health Policy Commission
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Introductions/Review and Approve Meeting Agenda and Meeting Minutes with Working Lunch
- Oregon Health 101
- Community Mental Health Overview
- Introduction to Community Health Clinics and Other Safety Net Providers
- Oregon's Community Collaborative
- Invited Testimony and Public Testimony
- Other Business and Discussion

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

(Digitally Recorded)

Chair Thorndike I. Call to Order/Introductions/Review and Approve Meeting Agenda and Meeting Minutes with Working Lunch.

- There was a quorum. Board, Committee Members and staff introduced themselves. October 2 meeting minutes were reviewed.

Motion to approve the October 2, 2007, meeting minutes was seconded.
Motion passed unanimously.

The following individuals were submitted for approval as Committee Members:

Eligibility and Enrollment:

- Felisa Hagins, SEIU Local 49, Portland
- Noelle Lyda, Ed Clark Insurance Inc., Salem
- Eric Metcalf, Confederated Tribes of Coos, Lower Umpqua & Siuslaw Indians, Coos Bay
- John Mullin, Oregon Law Center, Portland
- Susan Rasmussen, Kaiser Permanente Northwest, Portland

Finance Committee:

- Fred Bremner, DMD, Portland
- Judy Mushcamp – Confederated Tribes of Siletz

Federal Laws:

- Cheryle Kennedy, Confederated Tribes of Grand Ronde

Health Equities:

- Holden Leung, Executive Director, Asian Health and Service Center, Portland
- Joe Finkbonner, Executive Director, NW Portland Indian Health Board, Portland
- Laurie Powers, PhD, MSW, Professor, Portland State University, Portland
- Melinda Muller, Physician, Legacy Health Systems, Portland

Motion to approve the appointments to the assigned committees was seconded. **Motion passed unanimously.**

Jeanene Smith,
M.D., OHP

Jim Edge, DHS,
Division of
Medical
Assistance
(DMAP)

Kelly Harms,
Office of Private
Health
Partnerships/
Family Health
Insurance
Assistance
Programs
(FHIAP)

II. Oregon Health Plan 101 (see Power Point Presentation)

Jeanene Smith, M.D., provided information on the historical backdrop of the Oregon Health Plan (OHP); the prioritized list of Health Services maintained by Health Services Commission (HSC) and criteria for ranking services; and OHP 2.

Jim Edge, DHS, Division of Medical Assistance Programs (DMAP).

- Reduction of Oregonians in Standard Program due to Federal action.
- Approval to expand Standard program to 24,000.
- Ellen Lowe, Chair, Eligibility and Enrollment Committee, urged involvement in getting eligible individuals to sign up for expansion.
- Dialogue on per member costs for an individual in Plus package, child in SCHIP program and adults in Standard program, and capitated rates as calculated by independent actuary.
- Administrative fees, loss of provider tax and tax strategies discussed.
- Maps of OHP enrollments in Fully Capitated Health Plans (FCHP), Physician Care Organizations (PC), Dental Care Organizations (DCOs), and Mental Health Organizations (MHOs).
- Annual calculation of federal matching rates.
- Discussion on SCHIP allotment amounts carried forward and potentially reaching a ceiling in three years.
- Oregon operating under waivers due to demonstration projects which requires budget neutrality.
- Budget neutrality trend line and dollars available. Revenue resources for Medical Assistance Programs.

Kelly Harms, Policy and Legislative Liason for the Office of Private Health Partnerships, provided an overview of Family Health Insurance Assistance Program (FHIAP) (see Exhibit Materials 3).

- Eligibility, subsidy levels, and application/enrollment process.
- FHIAP Snapshot of Program Activity.
- FHIAP targets low-income, uninsured populations. Children in family must be covered before an adult can be covered. Designed to bridge people from a Medicaid program into private coverage.
- Program has a limited budget and a reservation list.
- HB 2519 passage in 2001, OHPHII waiver bill, resulting in program expansion.
- Is it member dependent or intermediary dependent? There is an agent referral program. Dialogue regarding training provided and outreach efforts to help people move into the best plan for them.
- On the Geographic Trends page of handout, the number in the "Other" category for accessing program by region is incorrect. Kelly will clarify and get the Board that information.
- Barney Speight will obtain information on how these subsidies compare with subsidies in other states.
- Discussion on reasons for failing to make premium payments.
- Individual program is more efficient due to electronic format while the group program is more labor intensive and requires monitoring. This is an important element to look at when considering expansion programs.
- Role of employers in FHIAP group market.

**Gina Nikkel,
Association of
Community Mental
Health Programs
(AOCMHP)**

**Mitch Anderson,
Community
Mental Health/FQHC,
Benton County**

**Karl Brimmer,
Community
Mental Health
Program/MHO,
Multnomah County**

**Rita Sullivan,
ONTRACK, Addictions
Contract with
Jackson County**

IV. Community Mental Health Overview

Gina Nikkel, Executive Director of the Association of Community Mental Health Programs (AOCMHP) (provided handout)

- Background of the Association, community MHOs and programs.
- Wasco/Sherman/Gilliam/Hood River counties constitute one County Mental Health Program (CMHP) and Morrow/Wheeler are one CMHP.
- MHO's (prepaid, capitated) and community mental health programs.
- Broad level overview.
- One-half of the counties contract out with private nonprofit organizations resulting in a wide variety of models.
- Community Mental Health programs administrative fees is about 2%, 0% for addictions, and, depending on the year, 1½ to 3% for developmental disabilities management while CMHOs get about 8% for administrative overhead. A 2007 survey showed that all MHO's put about half of that back into programs.
- Study by the Oregon Association of Counties and the wide variability on how much counties fund.
- Statutes, rules and service structures.
- In reference to a pie chart on county discretionary funds, the Board asked for a total amount? Gina Nikkel will forward that information.
- Community mental health as part of primary care and medical homes.
- Draft document of the AOCMHP and Public Health recommendations on primary care home which includes primary care homes accommodating various settings and patient characteristics, including severe and persistent mental illness; and supporting a multi-disciplinary team.

Mitch Anderson, Mental Health Addictions and Developmental Disabilities Service Director for Benton County and OHFB Delivery Systems Committee member.

- The role and responsibility of local Mental Health Authorities through statutes and counties.
- The current focus is on the crisis end due to heavy case loads.
- Are these things that can be handed back to state if counties absolutely cannot perform them? Yes, counties may decline, but are reluctant to do that as it is an all or nothing deal.
- Services are aimed at safety net or low income individuals with less focus on preventive services.
- Community mental health services fall into two areas: mental health and addiction services that look like primary care services model and, secondly, a social service arena between mental health and addiction systems that provides connections with out-of-office community supports, e.g. housing.
- Dialogue on the need for a partnership between medical and social service structure. How do we put those two things together?
- Programs built on evidenced based results, but involve some complex partnerships across multiple agencies.
- Putting services under the scope of the Federally Qualified Health Center (FQHC). Provides new funding source and allows for experiments with holistic care that identifies strengths and weaknesses.

Karl Brimmer, Community Mental Health Program/MHO, Multnomah County

- 90% of Multnomah county mental health services consists of nonprofit organizations and one profit and 10% provided through the County.
- Treatment services and addressing housing and employment needs.
- Multnomah's current funding level is 16 millions dollars.
- HealthCare Oregon and Multnomah County working with providers.
- Dialogue regarding the Alaska model demonstrating importance of looking at the whole person.
- Services provided through Central City Concern currently. Pilot project of nearly one year with all services in one location. Serves part of the mental health population but does not serve the severe and persistent mentally ill.
- A cost offset study conducted by the Washington state showed that when a person receives medication and/or minimal outpatient care, there is a savings in medical costs across the board including emergency room services. Offered to provide the Board with a summary of the report.

Rita Sullivan, ONTRACK, Addictions Contractor with Jackson County

- Treatment works.
- Discussed evidenced based practices, collaboratives and helping people become system independent.
- Breadth of services in addiction treatment may include housing help and instruction on how to be a good tenant.
- Treats people that have complications of poverty, criminality, etc.
- All members of the family participate as social support predicts the success of the client
- Looks at kids who suffer parental interruption and the affect on them.
- New model of foster parents includes involvement of the parents to curb the affects of the interruption.
- Housing with a Purpose involves the elderly as mentors which also assists elderly with independence.
- Help with employment and helping them to be good employees.

- *“There is a high cost of not adequately funding alcohol and drug treatment because it results in higher arrests, higher child welfare, higher foster care placements, emergency room, employment problems. .”*
- How do we identify who has a mental illness, how do they get into the system? A family member could call, through criminal behavior, or hospitalization. It is important to identify problems early.
- Responsiveness of post traumatic stress syndrome from war? There is a need but do not having the capacity.
- If we serve those at 100% to 150% of the FPL would that increase the numbers? Having a broader benefit would ultimately have better results and get more people into system.
- Joint letter by AOCMHP and Council of Local Health officials was presented to the Board and will be submitted to the Delivery Committee.
- Senators Jackie Winters and Margaret Carter are interested in the issue of returning vets and are working with General Caldwell.
- How does the seniors program work and how does this keep them out of the nursing home? Ratio will be two senior families to one returning recovery family. It keeps seniors young. Program idea is from Indiana. Seniors involved are not part of the mental health system.

Panel:
Craig Hostetler,
Oregon Primary
Care Association

Scott Ekbal,
Office of Rural
Health

Jackie Rose,
Oregon School-
Based Health Network

Tracy Gratto,
Coalition of
Community Health
Clinics

IV. The Healthcare Safety Net Panel (see Power Point Presentation)

Craig Hostetler, Executive Director, Oregon Primary Care Association (OPCA)

- Overview of Community Health Centers and Assn of Safety Net Clinics
- If it was fully funded what is the maximum number capacity? Outside-In turns out 25-30 people/day. Physical facilities capacity could expand 25-30%, after which would have to add facilities.

Scott Ekblad, Executive Director, Office of Rural Health, OHSU

- Isolated Rural Health Center Facilities (IRHCF).
- Core safety net – only source of care in community
- Rural Health Clinics, federally certified, located in underserved designations, provide primary care services, and a mid level practitioner 50% of time, and must be able to perform six basic lab services.
- Need access to better data – in order to be a Isolated Rural Health Facility would like to require to provide data to their office and offer a schedule of discounts.
- What is your total clients? Do not have number of people served as reporting is not required.

Jackie Rose, Nurse Practitioner, Oregon School-based Health Care Network (see Power Point presentation)

- Overview of the Oregon School-Based Health Care Network and barriers of children to health care.
- School-based health care (SBHC) is like a doctor’s office in the school.
- Helps decrease health disparities.
- Report on St. Helens’ Elementary school recently added a mental health therapist resulting in a 65% decline in discipline referrals.
- Funding challenges.
- Available on the DHS website: patient satisfaction survey (in DHS School-Based Health Center Annual Services report) and an SBHC cost modeling report by the State’s School-Based Health Center Office.
- A reimbursement study is currently contracted but not yet available.

- How many school-based centers are open year-round? There is a couple; this is something that is being explored.
- Did some of the funding come from universities? OHSU School of Nursing is the medical sponsor of the Beaverton Merlo Station center.
- How does this differ from the role of school nurses of the past? School nurse as liaison to the school, provides information. The school-based health center has a medical provider on site. Both are needed. (Referred to a pamphlet by State Health Division and Department of Education)
- How do schools go about setting up a school-based health clinic?
 - Different communities go about it different ways.
 - The Commission on Children and Families' survey of superintendents found that the single most important need was addressing health needs.
 - Washington County's collaborative efforts to develop a process for setting up a school-based clinic including writing grants.
- Health Centers at a school will accept other students throughout the school district, but there is a capacity issue.
- Involving the community is critical and flexibility on local control issues.

Tracy Gratto, Director, Coalition of Community Health Clinics, Multnomah County

- Community sponsored clinics and FOHCs in Multnomah County.
- Definition and identification of community sponsored clinics.
- In Multnomah County about 75% of funding is from local foundations and private donations.
- Do not have as much administrative overhead, but each model is unique.
- Volunteer contributions, faith-based contributions.
- Free Clinics Association.
- What are your recommendations for increasing access to health care without harming Community efforts? Partly, create a financial system allowing for some flexibility and building on models proven to work.
- Concern expressed about relying too heavily on volunteers.
- Barney Speight advised that the Safety Net Advisory Committee will report at the next Board meeting.

Oregon's Community Collaboratives (see Power Point Presentation)

Panel:
Mike Bonetto,
Zoomcare

Susan Stearns,
100% Access
Healthcare Initiative

Tracy Gratto,
CCHS and Project
Access NOW

Mike Bonetto, Central Oregon Health Care Collaborative, (COHCC) , Bend (see Power Point Presentation)

- Key elements of community collaboration learned from national models.
- What makes collaboratives work? Overview of eight critical activities. There are 600-700 collaboratives around the nation.

Susan Stearns, 100% Access Healthcare Initiative

- 2004 United Way Needs and Assets Survey revealed that the most pressing Lane county needs include access and affordability.
- There has been a dramatic rise in health care needs over past twenty years of the survey.
- 1 in 5 Lane county residents is uninsured compared to 1 in 6 in Portland.
- Coalition is made up of over 50 organizations, the CEO of every major health care organization is on the board, in addition to key business leaders, nonprofit executive directors, government leaders, and other community representatives.

- Starting with small discrete projects which is building trust and establishing relationships that will be needed to accomplish universal care.
- Completed a comprehensive analysis of the utilization of emergency department for 2005 and 2006. Data from 2007 is forthcoming and with its analysis will be able to develop three-year trend information.
- Prior to the 100% Access Health Care Initiative, the safety net clinics had never met together.
- Lane county safety net clinics include one FOHC, one Volunteers-in-Medicine Clinic (a national volunteer provider model), a network of school-based health centers, and the White Bird Clinic, a 30-year old collective providing care to homeless, mentally ill and other hard-to-reach populations. Recently added, Center for Community Counseling, a Volunteers-in-Medicine-like model.
- Creation of a laminated card listing complete scope of practices for the uninsured.
- During the initial year, the safety net organizations gathered information and was able to estimate that about 18,000 patients have been covered, about 1/3 of the Lane county uninsured population.
- United Way, Lane County, has been licensed by Stanford University to offer the chronic disease self-management program, a 6-week non-disease-specific model designed for a community, not health care, setting. Offered in both English and Spanish.

VI. Invited Testimony and Public Testimony

- **Tonya Stewart, MD, for the Palliative Care Physician's Roundtable**, presented testimony for the need to include "*. . . reimbursement to primary care providers to have conversations about goals of care or time spent reviewing and documenting the patient's desires regarding the Physician's Order for Life Sustaining Treatment (POLST).*" Written testimony provided.
 - Barney Speight requested contact information for future input.
- Testimony by Ellen Pinney will be deferred to the February meeting.

VII. Other Business and Discussion

- Next meeting is February 19 at Kaiser Town Hall in Portland.
- Two reports on the docket are 1) general update on Board and Committees and 2) overview of the exchange.
- February 19 will include an update from Safety Net Advisory Committee.
- Feedback from Board to Barney Speight revealed a desire for more discussion time at the meetings. He will be providing information on Committee updates.
- Discussion of legislative session format for progress reporting.
- Ellen Pinney joined Ellen Lowe in supporting obtaining eligible individuals to apply in February for expansion of Standard Health Plan.

Chair Thorndike VIII. Adjourn

The meeting was adjourned at approximately 5:05 p.m.

The next meeting for the OHFB is February 19, 2008, Kaiser Permanente Town Hall, Portland.

Submitted By:
Paula Hird

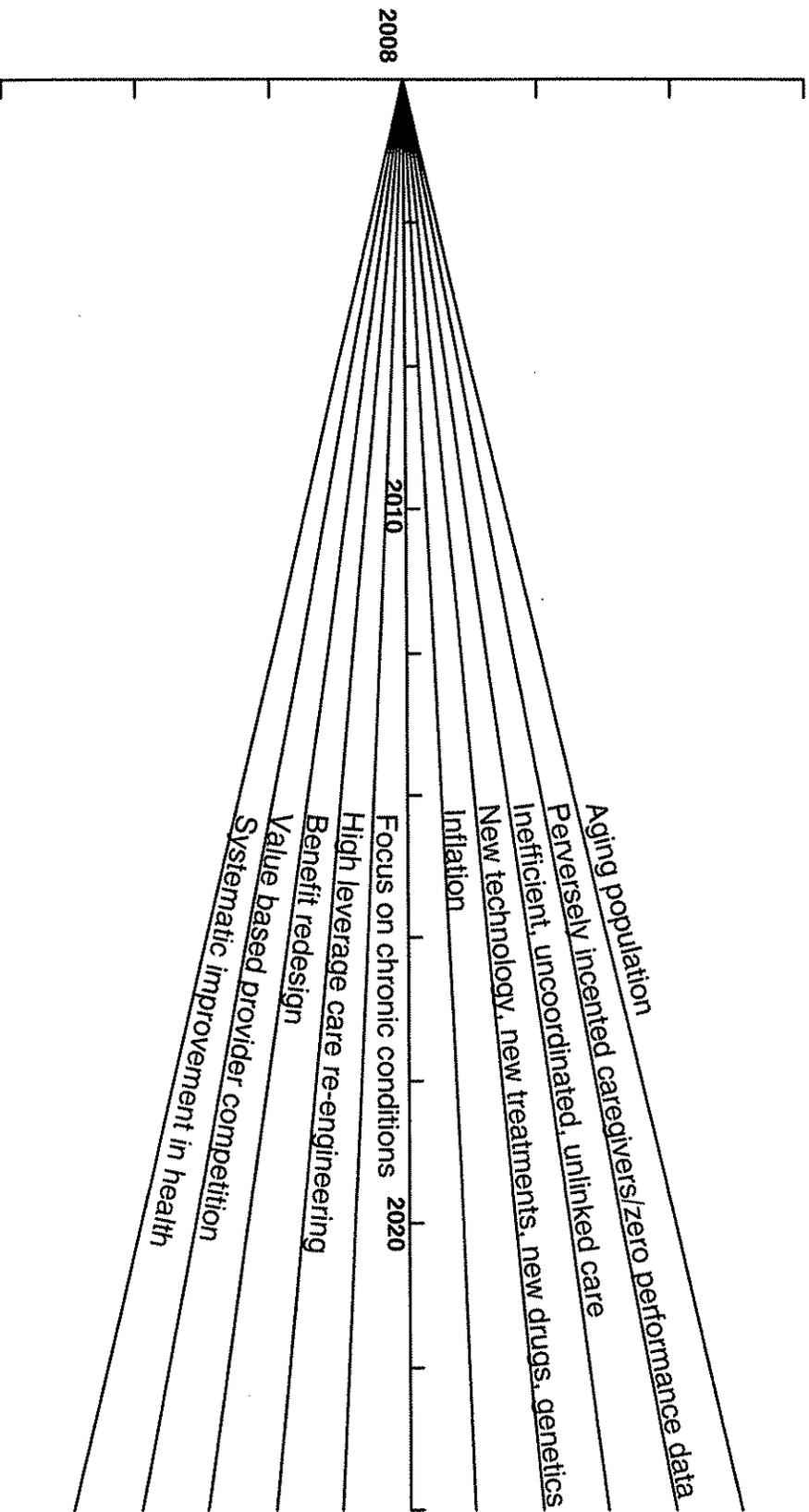
Reviewed By:

EXHIBIT SUMMARY

1. Health Fund Board Draft Meeting Minutes
2. Medicaid Fact Sheet
3. FHIAP Snapshot of Program Activity
4. Community-Created Health Care Solutions in Oregon
5. Map of 2007 Community Collaboratives by County
6. Lessons from Local Access Initiatives: Contributions and Challenges, Commonwealth Fund
7. Collaborative Problem Solving by States and Communities
8. Health Care Safety Net Definition
9. Map of Oregon Safety Net Clinics by County
10. FHIAP Brief
11. FHIAP Benchmark

DRAFT

Cost Drivers and Mitigators For American Health Care



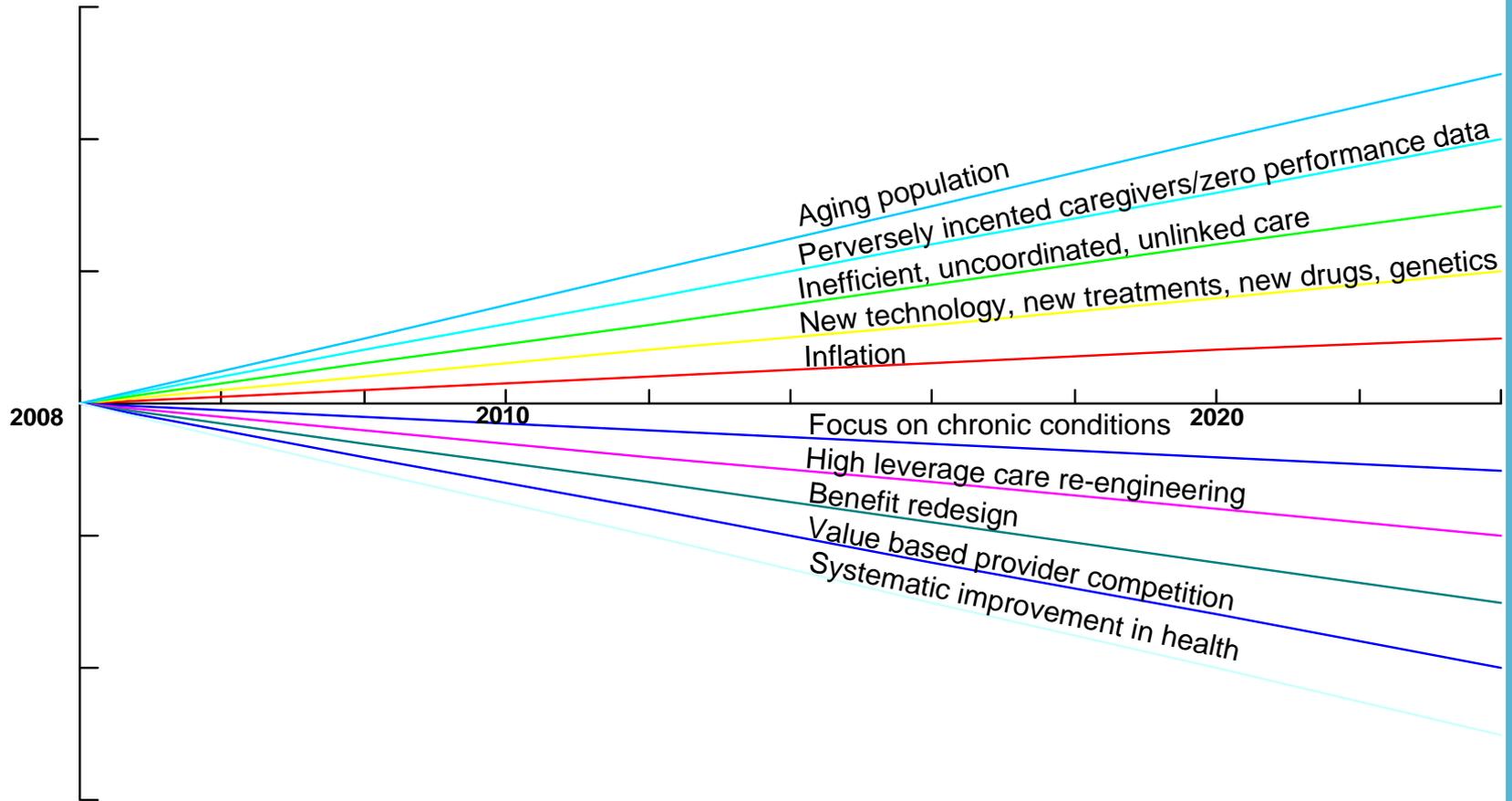
Health Care Reform Now!

George C. Halvorson

Chairman and CEO, Kaiser Permanente

February 19, 2008

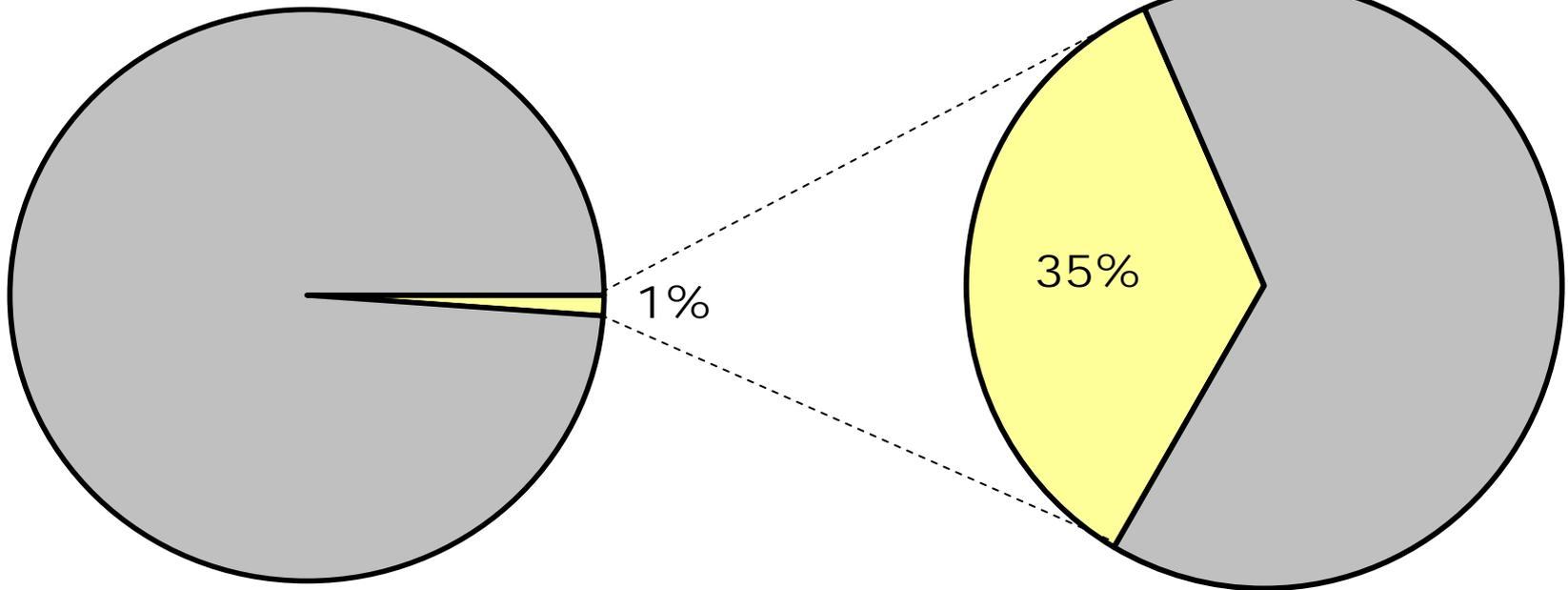
Cost Drivers and Mitigators For American Health Care



Cost Distribution of Care

Population

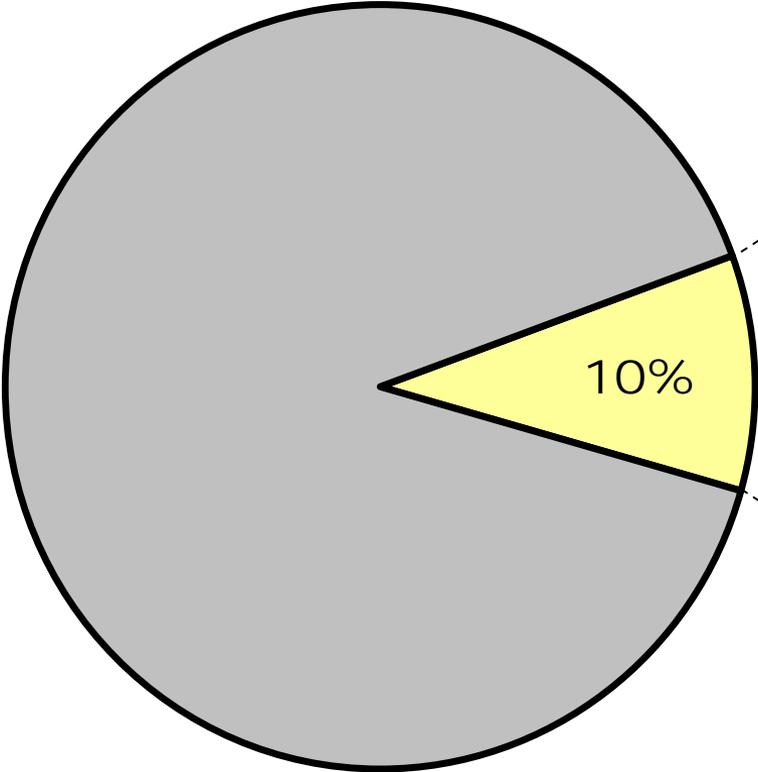
Cost



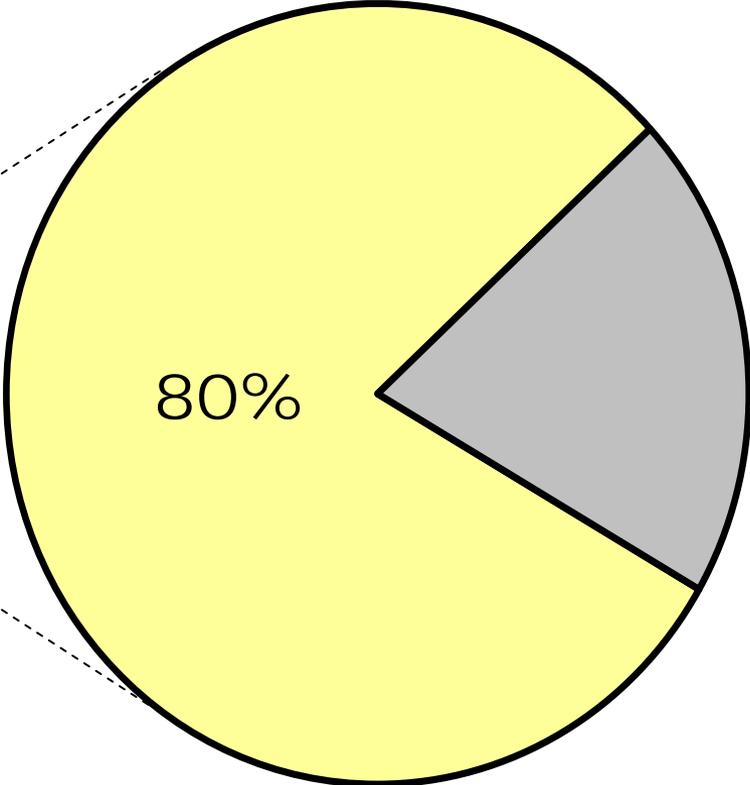
\$300 per month average cost

Break even cost insuring one percent: \$12,000 per month

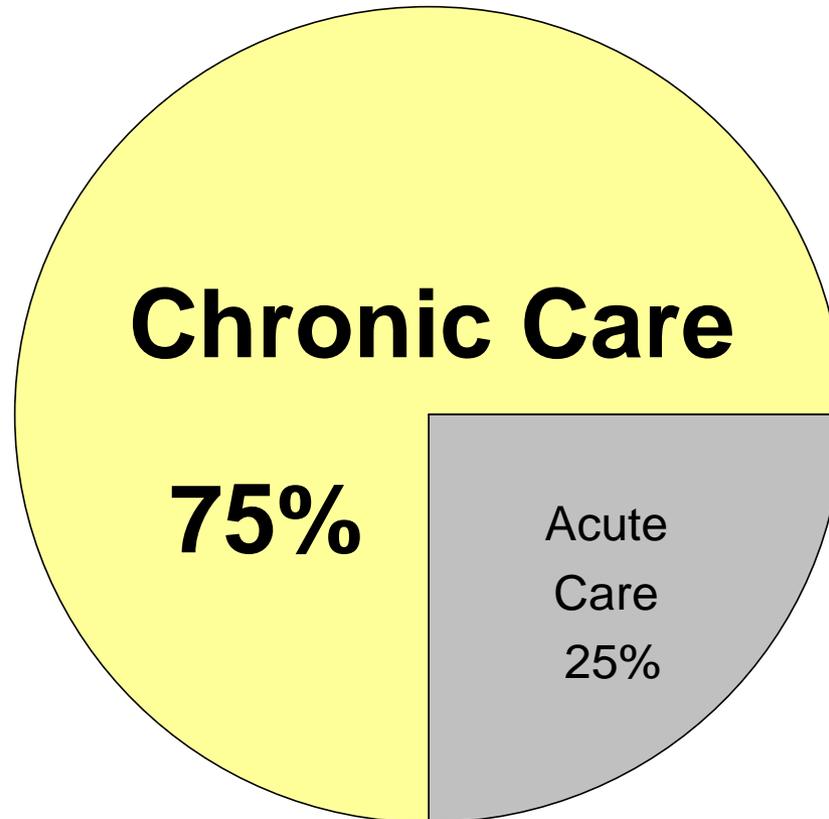
U.S. Population



U.S. Care Costs

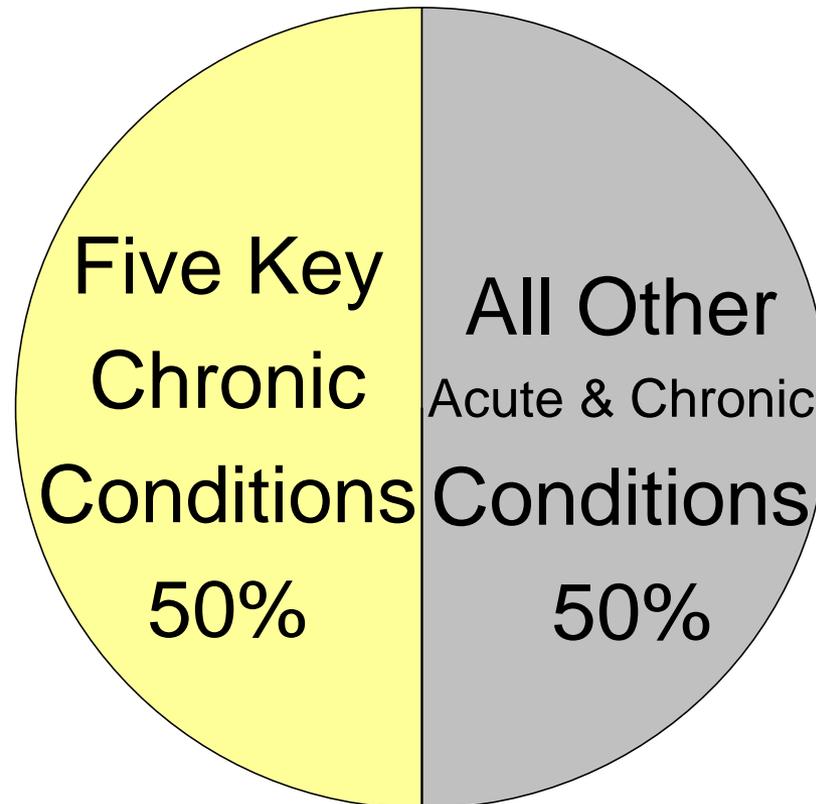


Total Cost of Care In America



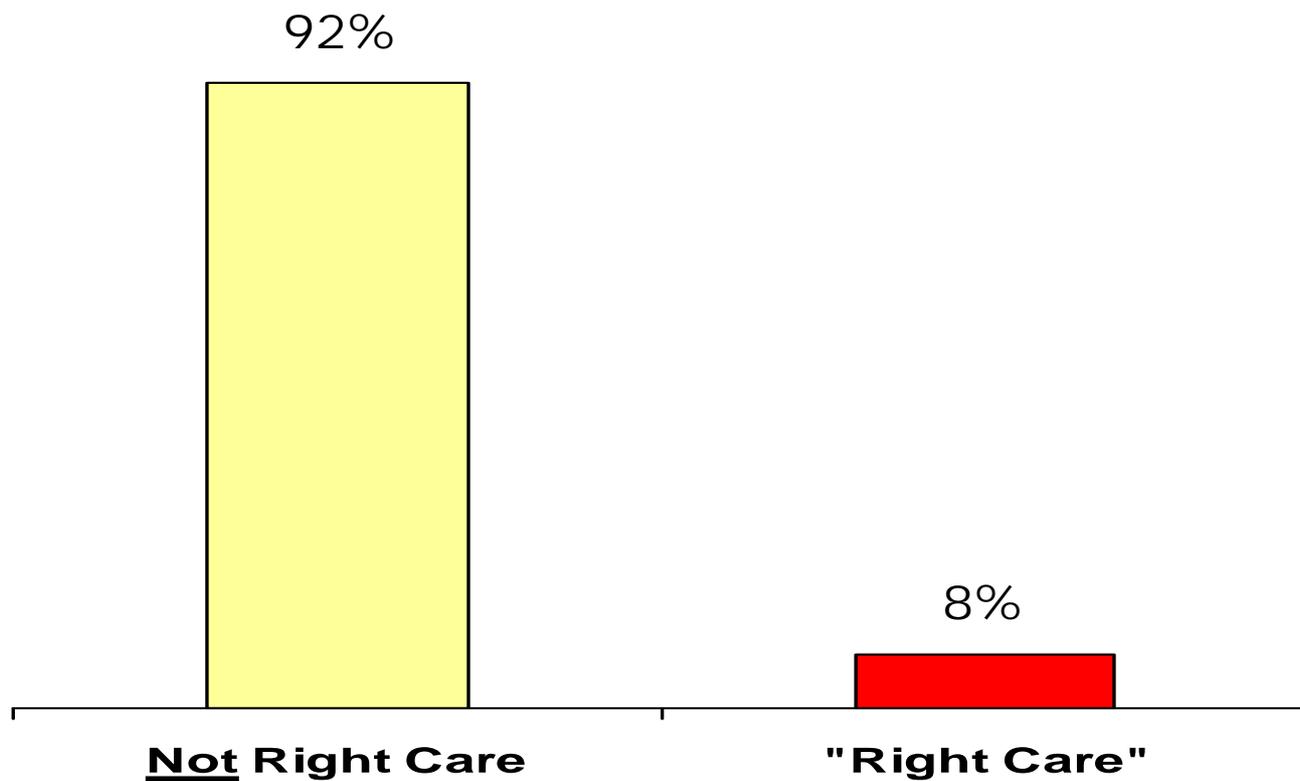
Chronic Care vs. Acute Care

Total Cost of Care in America

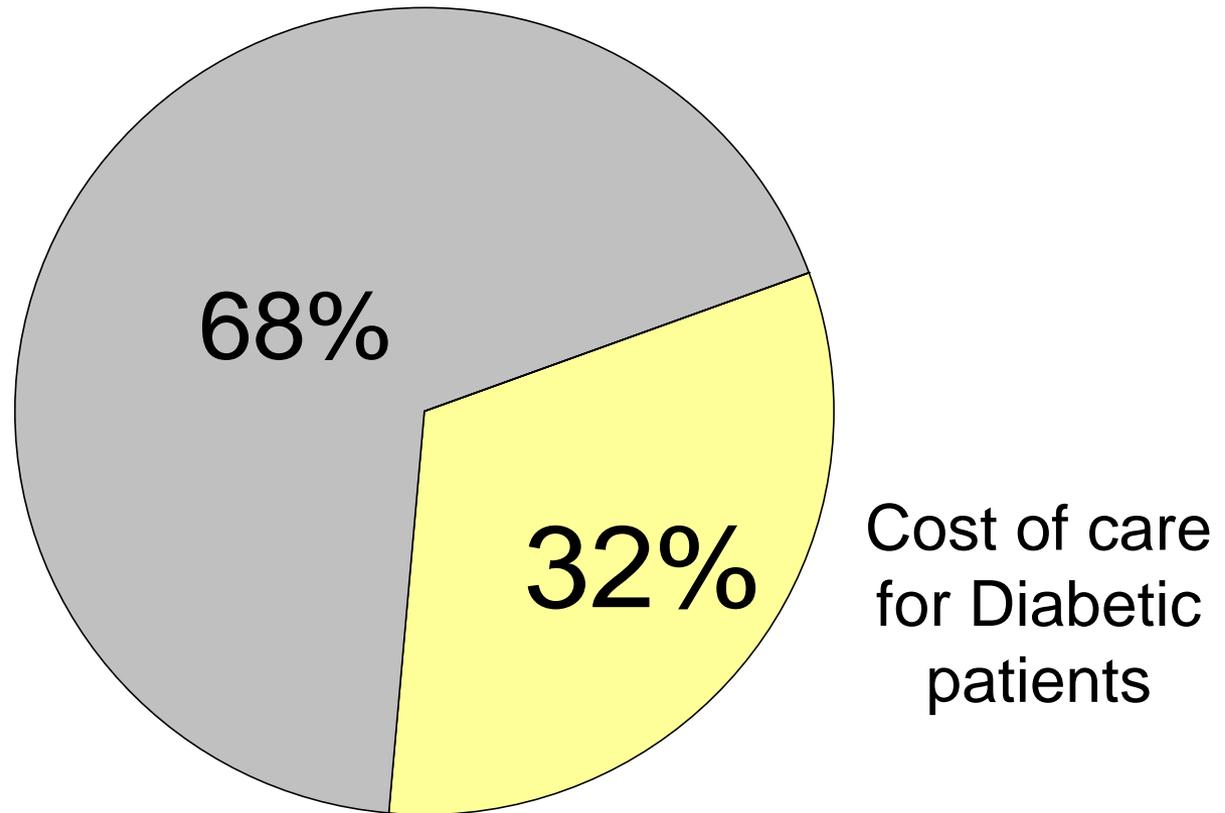


Top Five Chronic Conditions

Percent of American Diabetics Receiving "Right" Care

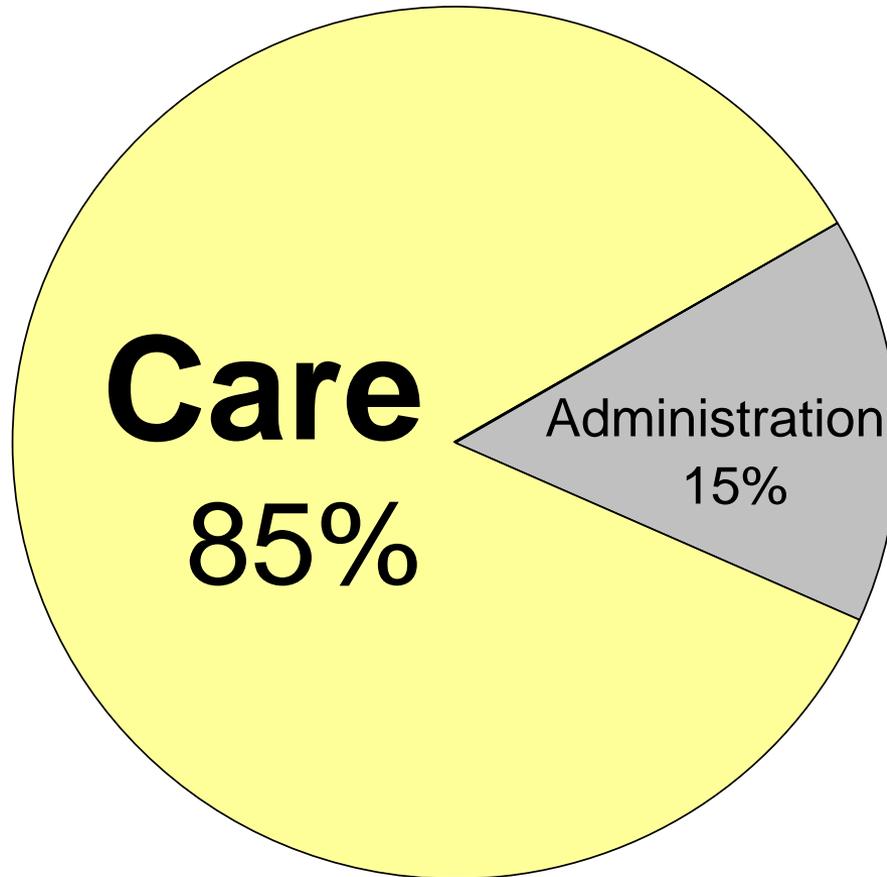


Medicare Diabetes Expense

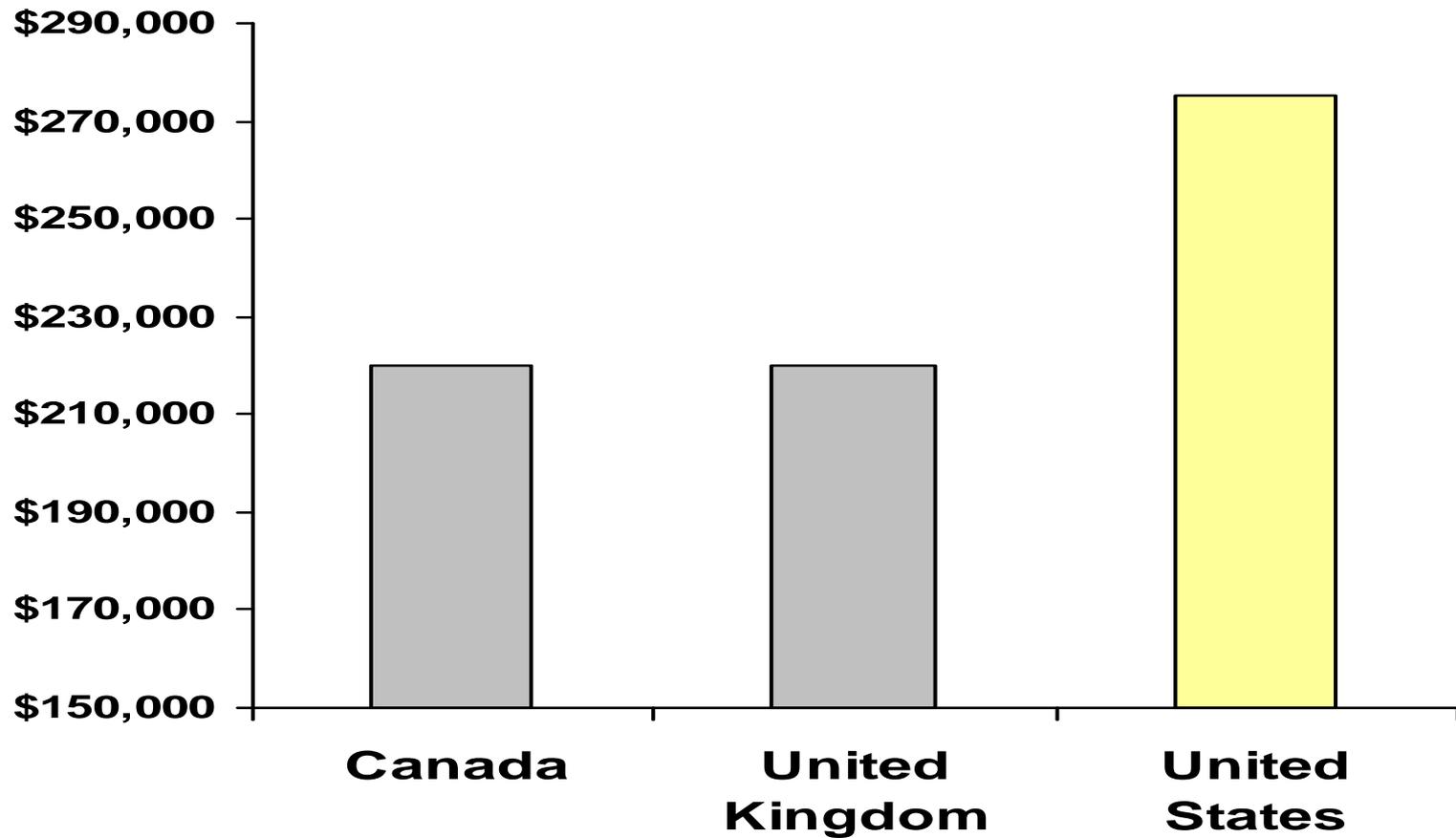


As a Portion of Total
Medicare Costs

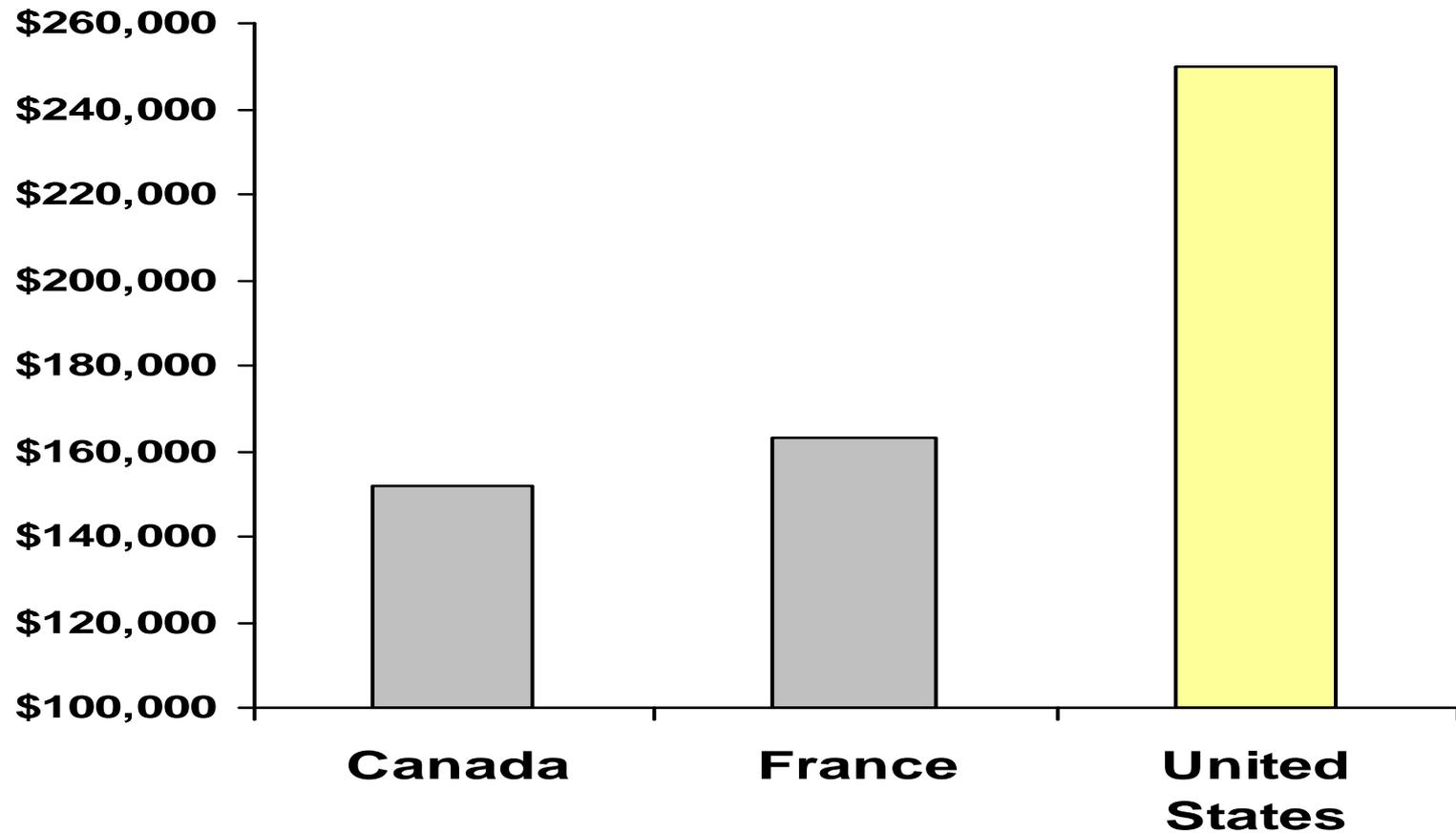
U.S. Health Care Costs



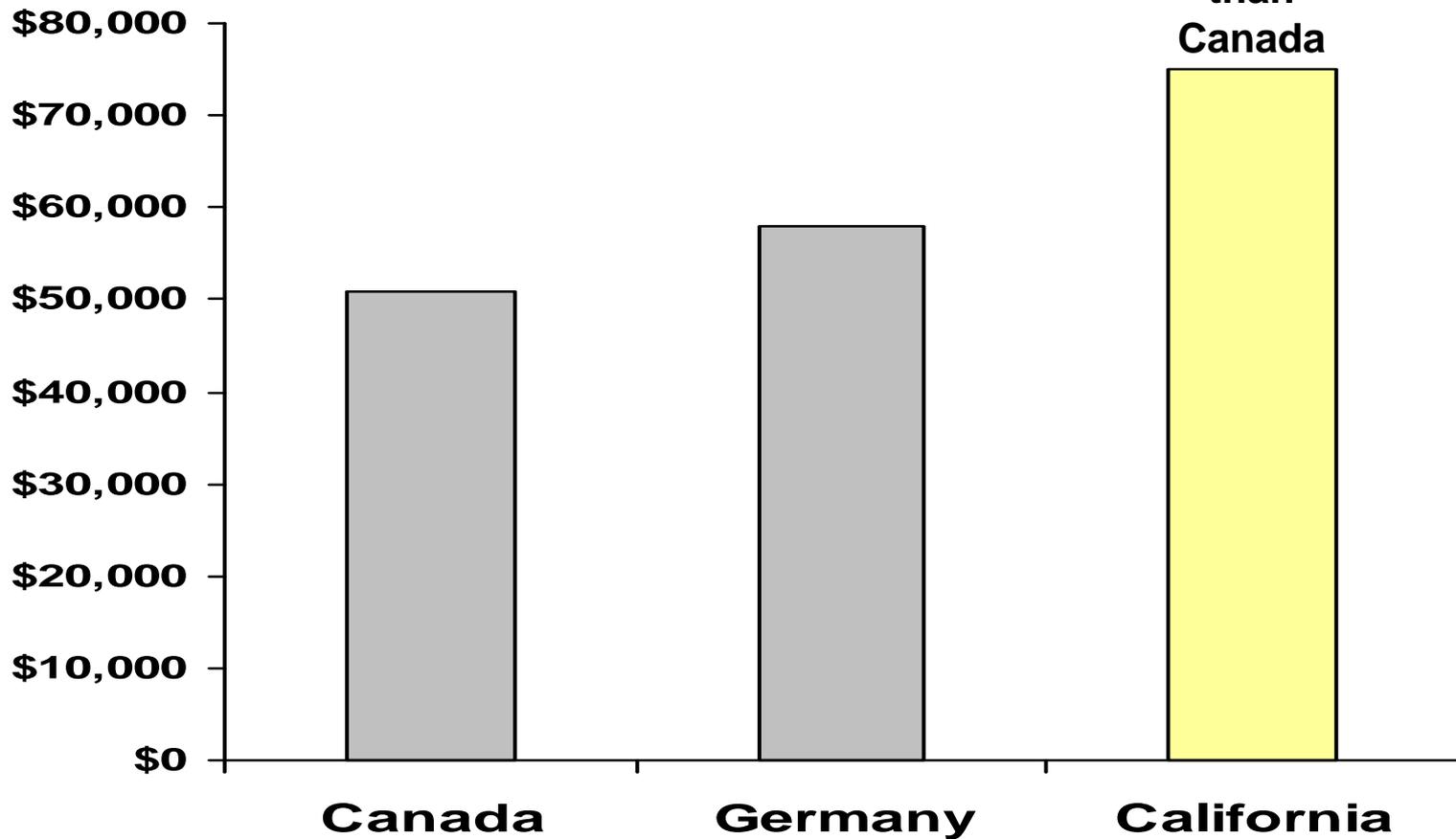
Obstetrician Income



Medical Specialist Income

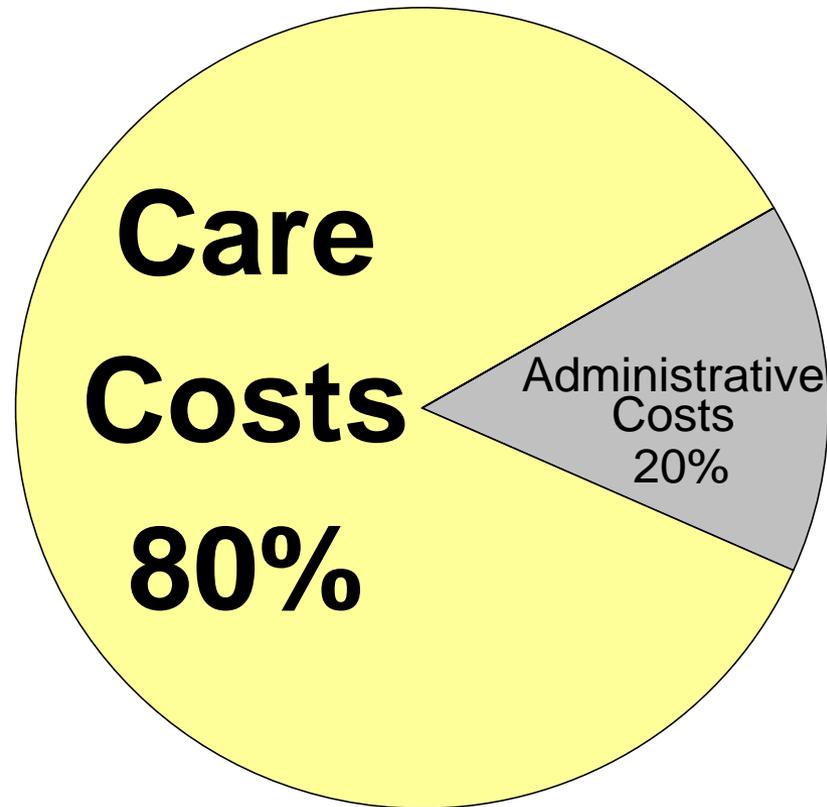


Comparative Nursing Salaries



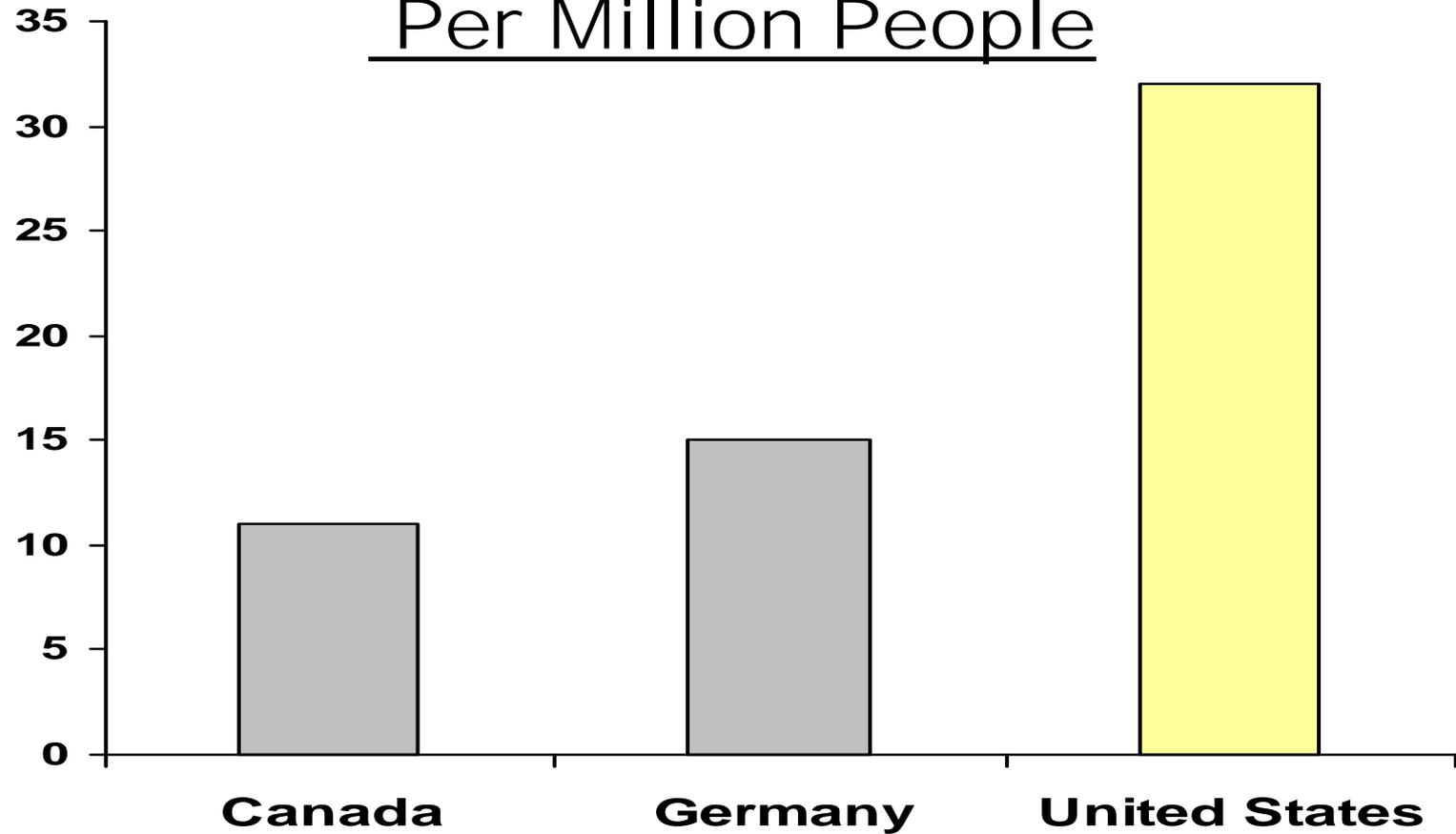
Source: OECD, BLS

Cost Differences -
U.S. versus Canada



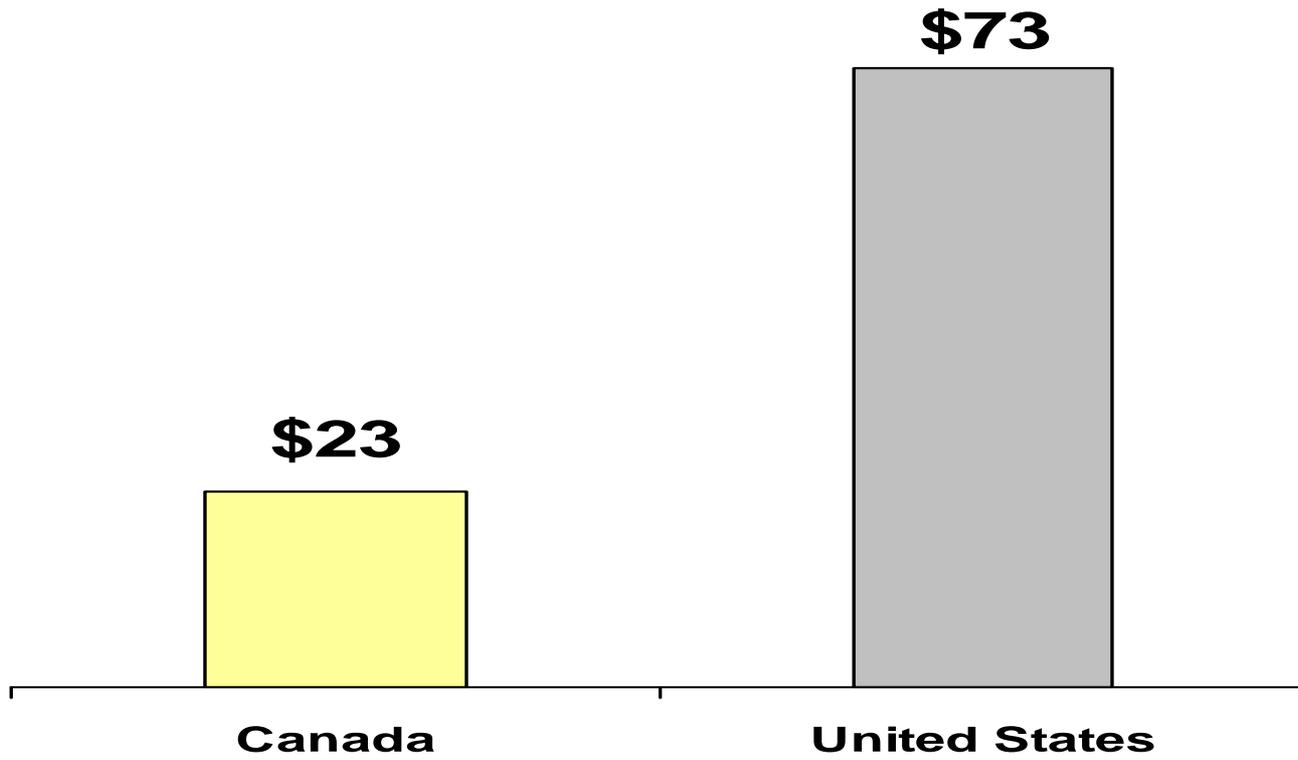
Number of CT Machines

Per Million People

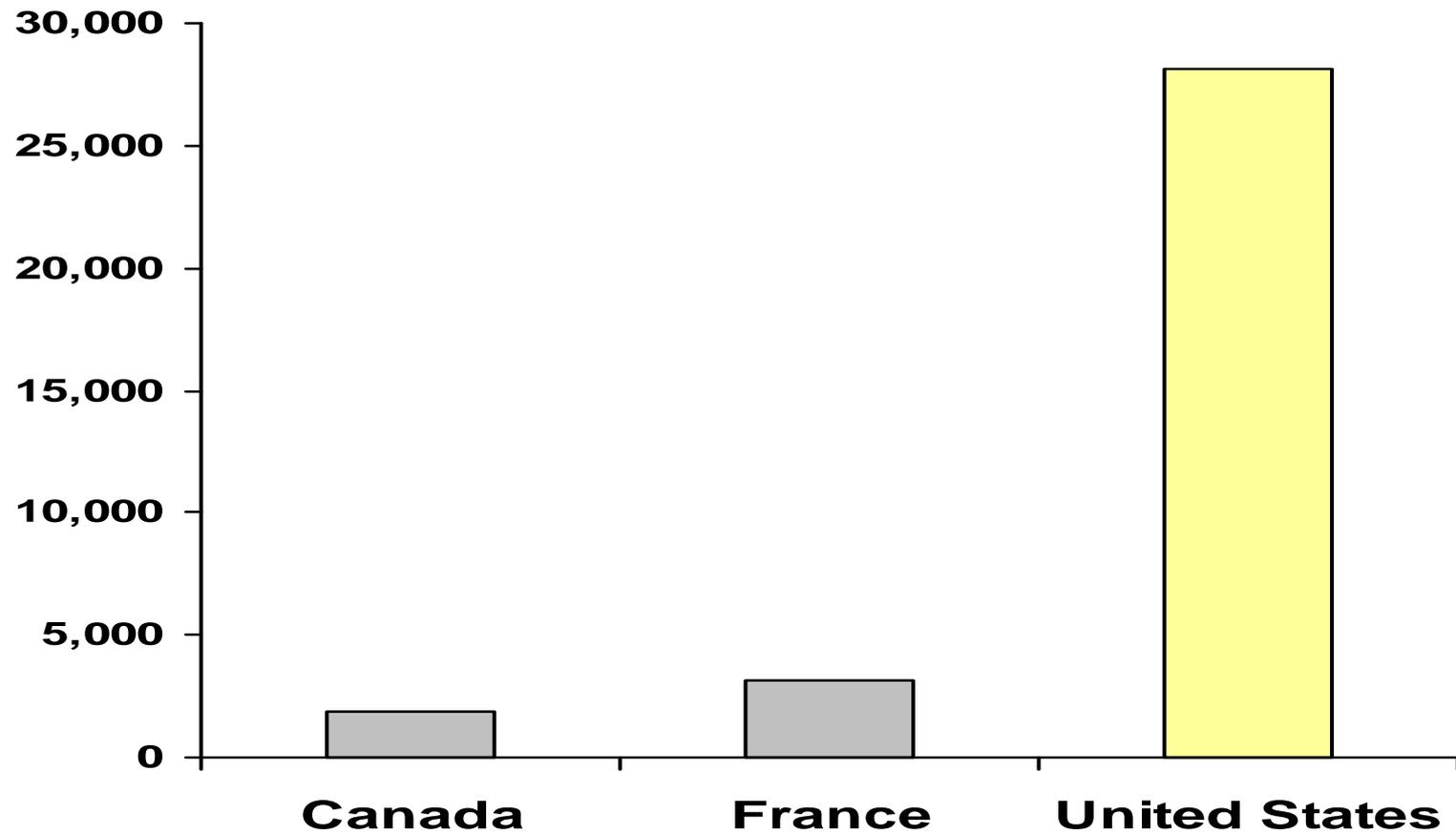


Source: OECD

Office Visit Fee

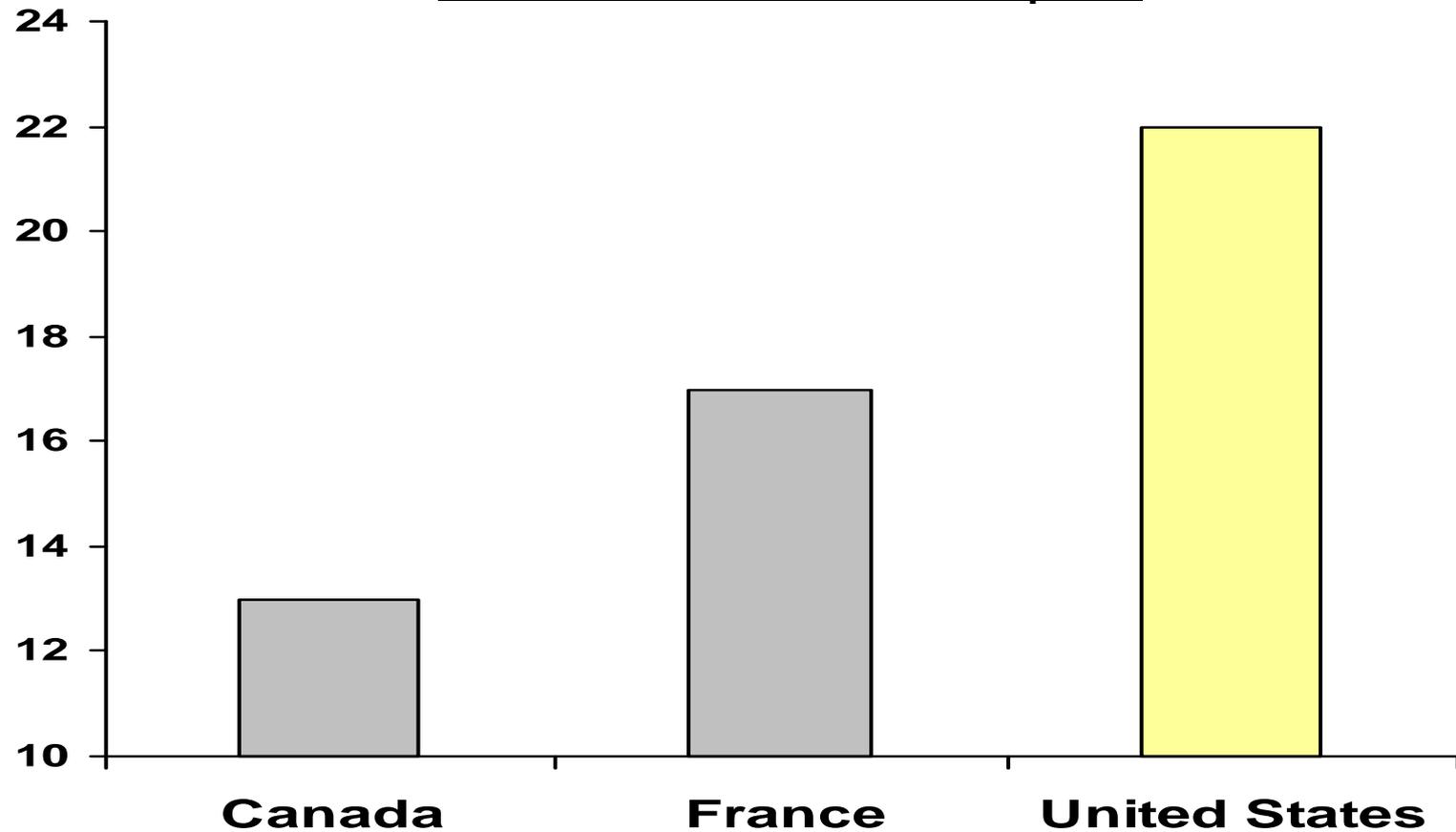


Total Transplants



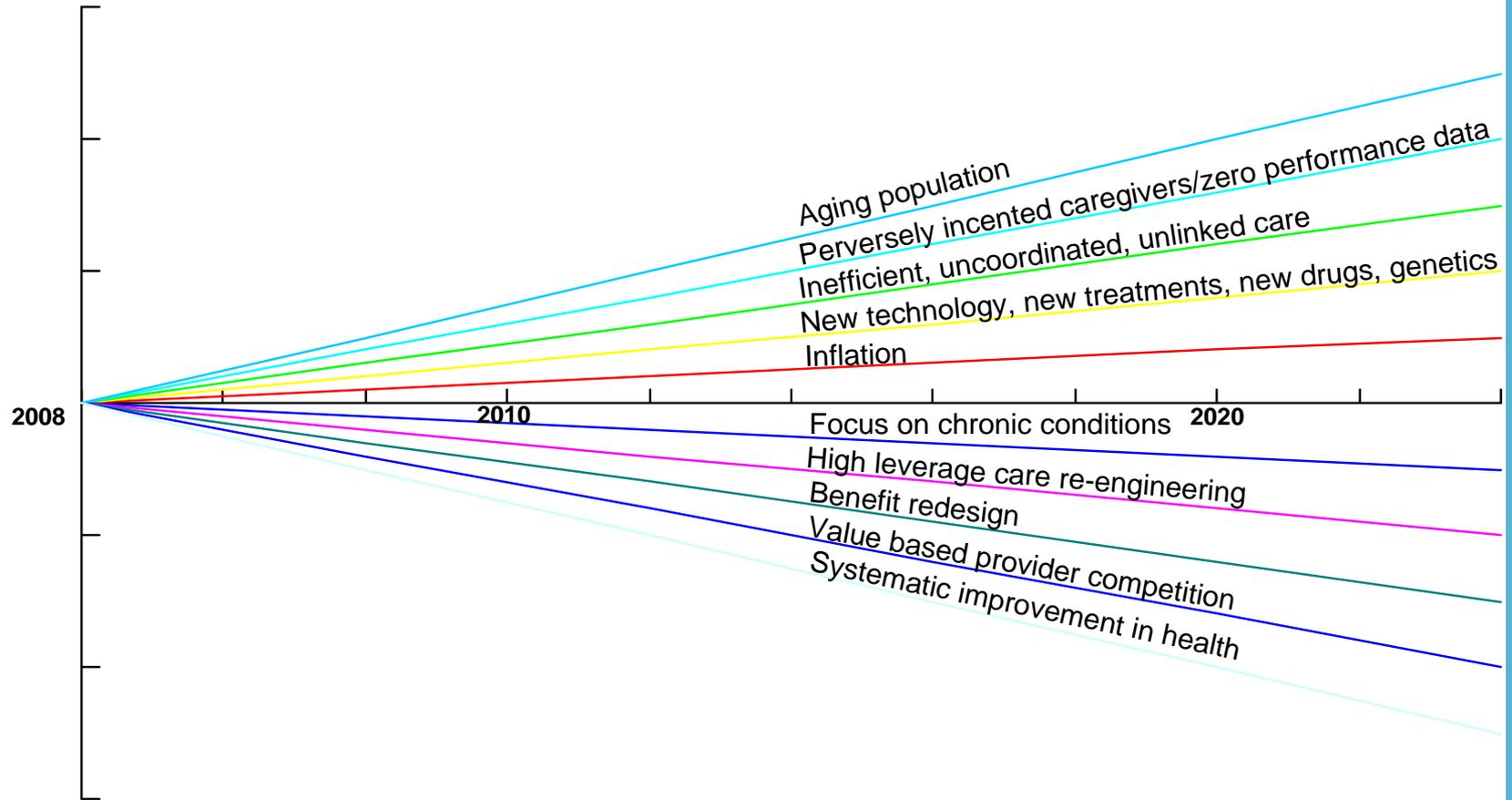
Source: OECD, BMJ

Liver Transplants Per Million People

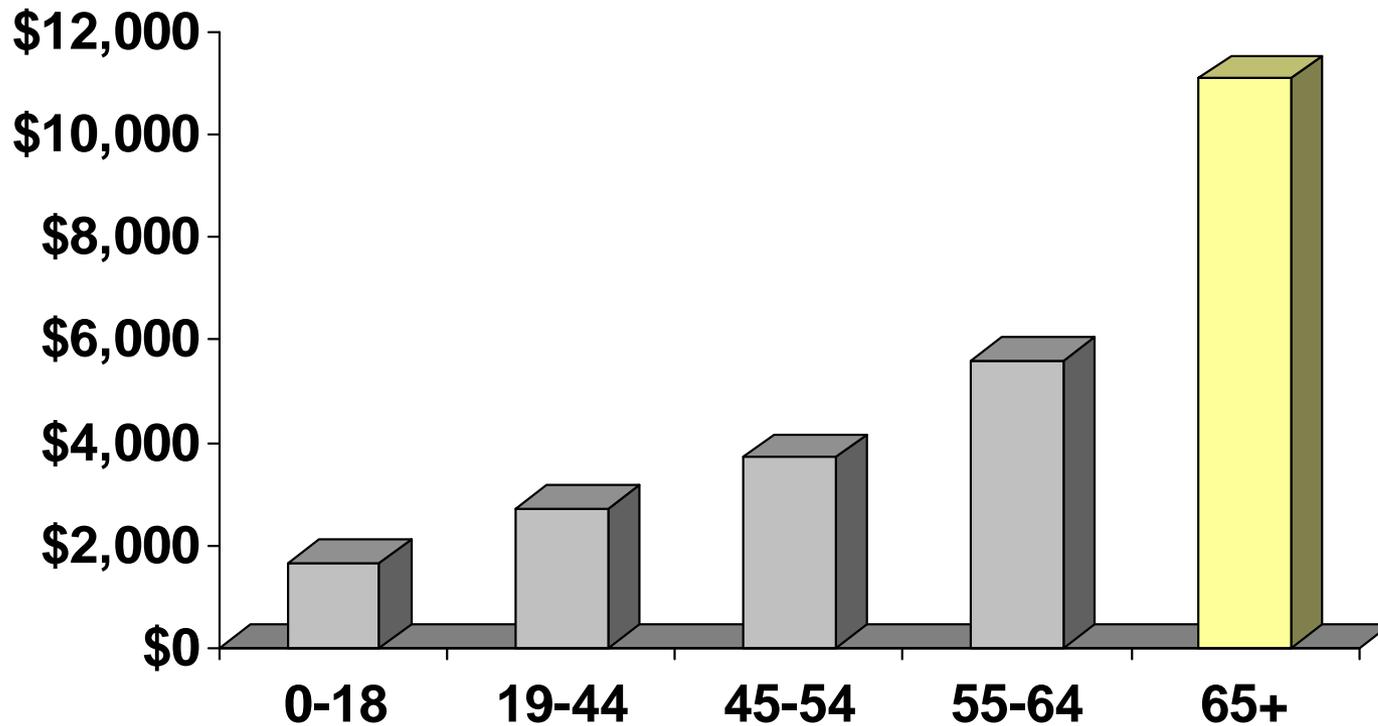


Source: OECD

Cost Drivers and Mitigators For American Health Care

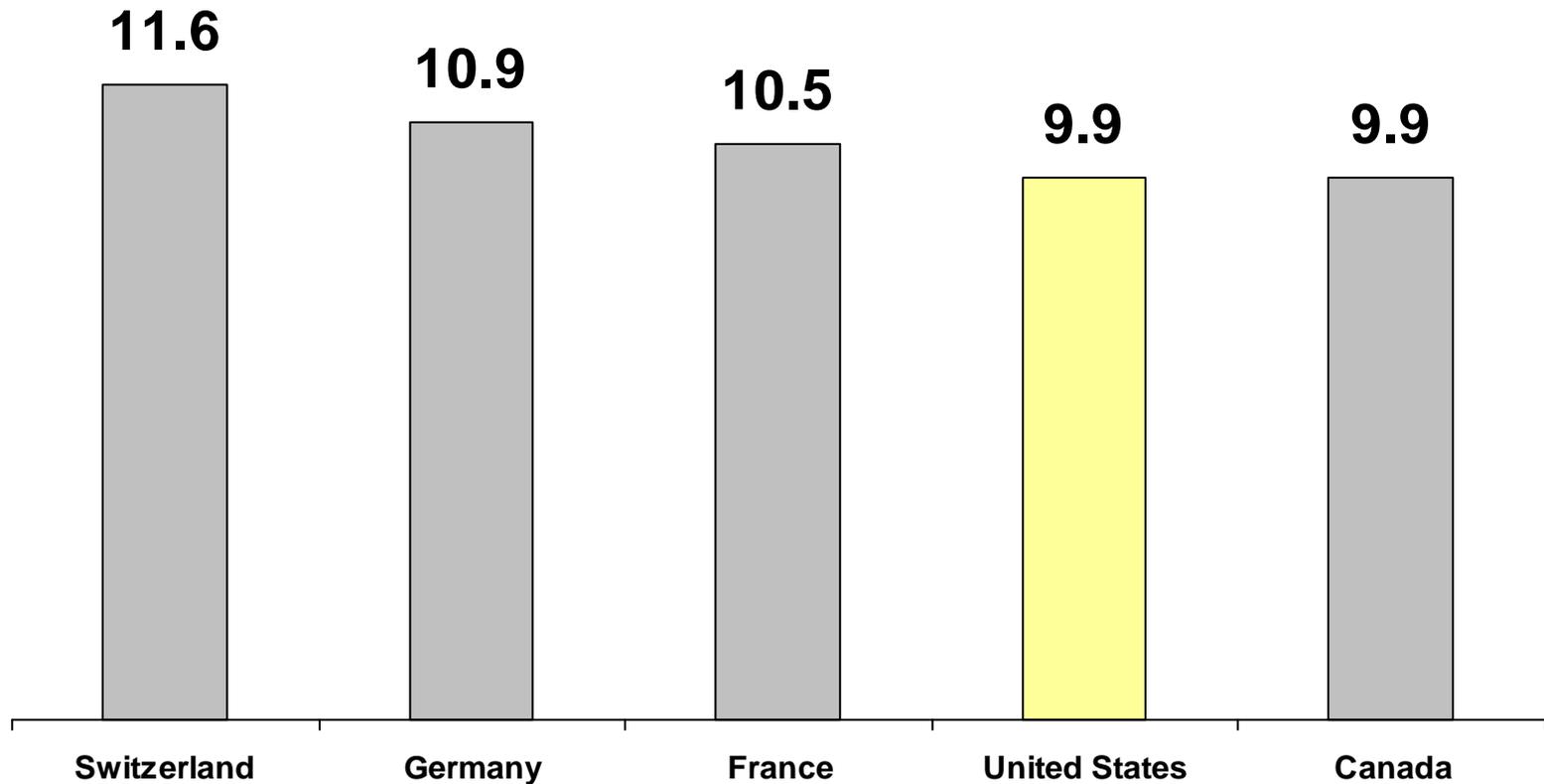


Per Capita Annualized Health Care Costs By Age Group



Source: CMS

Health Care Expenditures as Percentage of GDP Minus the Top 1% of American Patients



We Need

1) Focus

2) Tools

3) Health

The Cost Mitigators can offset the Cost Drivers and give us better care at a cost increase that approximates or beats inflation.

We just need to move the health care reform debate from rhetoric about subpoints to commitment about improved care.

Focus

(Community collaboration)

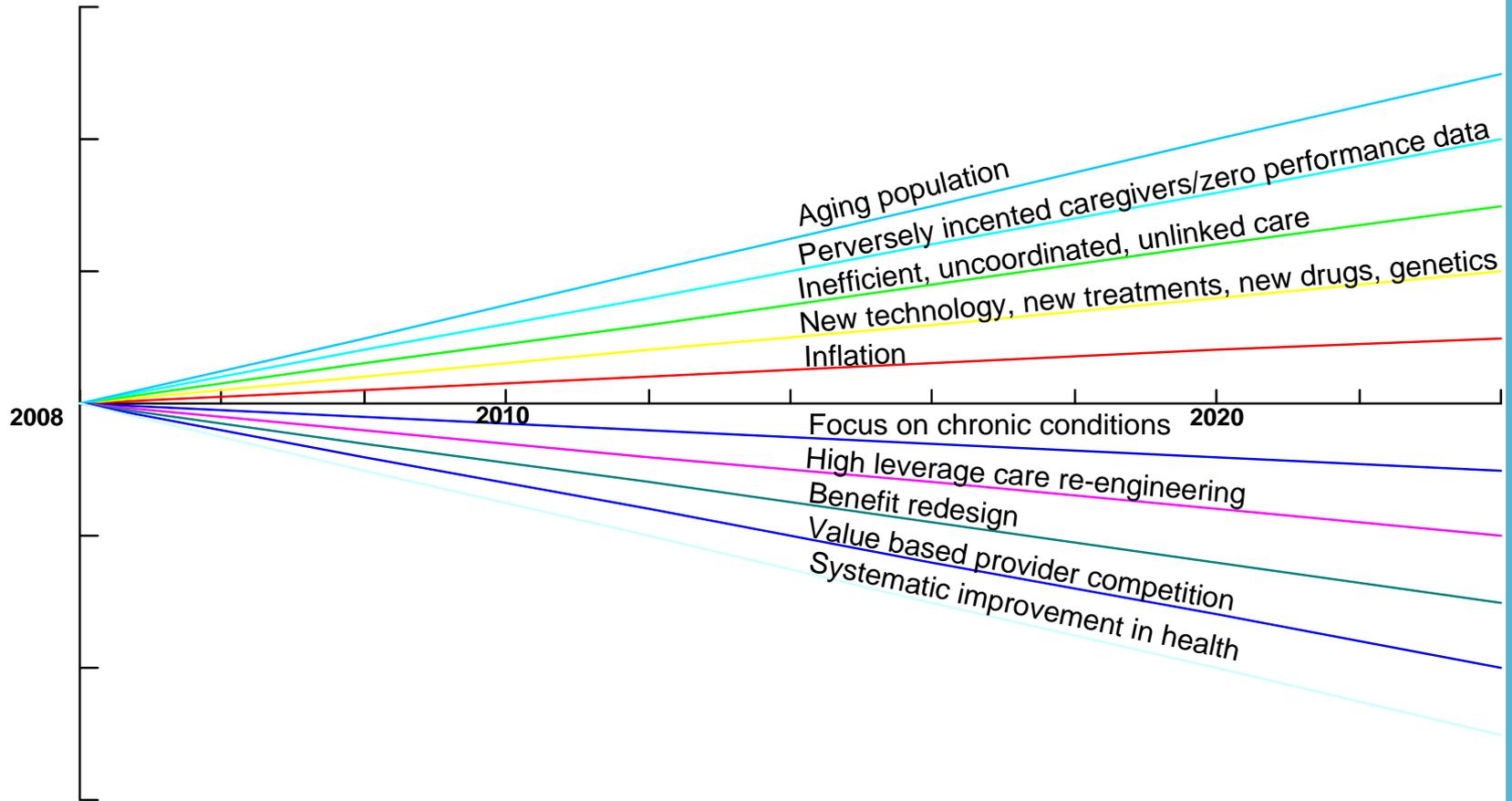
Tools

(Focused care registries fed by PHRs/claims data)

Health

(Smoking, transfats, fats, activity levels)

Cost Drivers and Mitigators For American Health Care





Update and Public Input

The Road to Health Reform: A Community Meeting on the Healthy Oregon Act

2/19/08

Community Meeting Dates and Locations

August 16th, Portland
 August 23rd, Medford
 August 26th, Newport (2pm - 4pm)
 September 25th, Gresham
 September 6th, Salem
 October 25th, Eugene
 October 28th, Dallas
 October 29th, Lincoln City
 December 3rd, Salem

Community Meeting - Junta De Consultad - Sept 25 Gresham City Hall

Finding the Road to Health Care for All
2007 and the Oregon Legislature

Buscando el Camino a la Asistencia Medica Para Todos
En 2007 Y La Legislatura De Oregon

Tuesday, Sept 25
6:30 pm to 9:00 pm

Gresham City Hall
3333 NW Gresham Parkway

Martes Sept 25
6:30 pm to 9:00 pm

Municipalidad de Gresham
3333 NW Eastman Parkway

For information contact:
Paula Andujar-Gonzalez
Email: paula@ohac.org
503-789-1379 ext 19

Presented by:
OHAC
Oregon Health Action Campaign
2007 Avenue A, Suite 1, New 38
Salem, OR 97301-3801 (503) 789-1379

ACORN
21224 Forest Blvd., Portland, OR 97206
503-711-7127

2/19/08

2

Meeting Agendas

Welcome and Introductions: what do you want to take away from this meeting.

Visualization exercise: Designed to help participants visualize percentage concepts.

Blue slips: 2 out of 10 slips of paper in the audience. You represent the uninsured. 20% or 2 of 10 people at least uninsured at some point during year.

Green slips: 3 out of 10 slips: Represent Medicaid and Medicare enrollees.

Pink slips: People with private insurance. 5 out of 10 people in the room. Most of you, 80% get it on the job. 20% of you have it because you buy it. Of those of you who get your insurance on the job, half of you are in plans that are regulated by the state, half of you are in self-insured plans.



AGENDA

**Finding the Road to Health Care for All in Oregon
2007 and the Oregon Legislature**

Legislative Community Meeting

Thursday, Oct 25

6:00 pm to 8:30 pm

Legislative Library

Lawton State

600 W. 10th, Eugene

1. Welcome and Introductions
2. Viewing Current Health Issues in Oregon and your community
3. Measure 52 and Healthy Kids Understanding: The Basics
4. All the rest of the Measure 52 stuff?
5. Next steps: Making sure the plan works for you.
6. Adjournment

Presented by

Oregon Health Action Campaign
388 Academy Ave., Ste. 1, Suite 11 - Salem, OR 97302 - (503) 861-6800 (503) 716-1169

Health Care for All Oregon

2/19/08

5

Community Check-Ins

How many of you are now in a health plan that you would consider 'accountable' as described in the Healthy Oregon Act?

Who in your mind is required to participate in an accountable health plan after this plan is developed? Does this bill define the benefits that an accountable health plan must provide?

2/19/08

6

Grounding for Next Phase of Meeting

According to the Healthy Oregon Act, all Oregonians will be required to participate in an accountable health plan.

You and the public have some power here: in order to make the Healthy Oregon Act vision real, legislators will need to vote for it. They will need to hear from you that the plan will work. So our question today is: What would it take to make a health plan accountable to the health needs of you and your family?

OHAC will present this information to the Oregon Health Fund Board.

Your role is not done after this meeting.

2/19/08

7

Meeting Process, Result Comments and Recommendations

We invited elected officials from the community. A few came. Some legislators who were invited said they knew very little about the bill. That we should invite Senators Bates and Westlund. **Recommendation:** proactive steps need to be taken by OHFB members and staff to inform all elected officials about the process and goals and provide them with an opportunity for input before the proposal is finalized.

Very few participants had any concept of the content of the Healthy Oregon Act. **Recommendation:** OHFB members and staff to inform the public about the process and goals and provide them with an opportunity for input before the proposal is finalized.

When Healthy Oregon Act requirements for an accountable health plan were reviewed in the meeting, very few people (10% - 20% max) identified themselves as people who were in a plan the Healthy Oregon Act describes as "accountable."

Despite vast differences in experience, age and demographics of meeting participants, there was common articulated informed understanding of the extent to which the health system does and does not work well for all those within it and clarity about what it would take to make a health plan accountable.

2/19/08

8

**SB 329, the Healthy Oregon Act
Accountable Health Plans**

One goal of 329 is to **“Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.”**

Section 12 of the Act requires all Oregonians who do not have health coverage through their job or the Oregon Health Plan to “participate in the Oregon Health Fund program”.

“The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals. The board shall establish subcommittees....to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insurance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities.

The proposal must ensure that each accountable health plan:

- 1. Does not deny enrollment to qualified Oregonians....;**
- 2. Provides coverage of the entire defined set of essential health services;**
- 3. Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;**
- 4. Offers a simple and timely complaint process;**
- 5. Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;**
- 6. Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;**
- 7. Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services**
- 8. Ensures that all enrollees have a primary care medical home;**

Compilation of essential Accountable Health Plan components

Summary of responses from 11 community meetings to these questions:

- What would make a health plan accountable to the needs of you, your family and your community?
- What are the essential ingredients of an insurance plan that you would be required to participate in and pay for?

Notes / Qualifications: The accountable health plan (AHP) part of the meetings started with a review of the Healthy Oregon Act principles and goals and Healthy Oregon Act description of the components of an accountable health plan.

Desired components of 'accountable health plans' raised at all community meetings:

- a. Choice of providers.
- b. Comprehensive: dental, vision, mental health, physical, prescriptions, therapies, hospice care, DME, etc.
- c. All plans must offer same benefits. Uniform benefits.
- d. Premiums and out of pocket costs for services are affordable for families of all income levels.
- e. Prevention should be a priority.
- f. All plans take all people who make the selection.
- g. Include all pre-existing conditions. No pre-existing delays.
- h. All plans are Non-profit.
- i. There is an independent patient advocacy/ombudsman function.

Desired components of 'accountable health plans' raised at more than one community meeting.

- a. Access to every type of licensed and certified practitioner (access to non-allopathic practitioners).
- b. Safety net clinics as part of every plan's network.
- c. Nurse advice line.
- d. Plans have client advocates / navigators / coaches
- e. Provide for out of state services in case of travel.
- f. Promotes community based outreach/education.
- g. Patient centered care
- h. Plans make prompt payments to provider.
- i. Efficient, effective and transparent billing procedures.
- j. Services are fairly priced.
- k. All plans pay providers the same amount for the same services.
- l. I can keep the plan as long as I like. (I can take the plan with me.)
- m. Protect confidentiality of provider – patient relationships. Protect medical records and their confidentiality.
- n. Provides patients with access to their own medical records, copies of what's written.

COMPILATION OF ALL ACCOUNTABLE HEALTH PLAN RESULTS

Notes / Qualifications:

- *The categories (Provider / prevention / plan responsibility etc) were not mentioned in the meetings. Transcriber utilized them to organize responses.*
- *The accountable health plan (AHP) part of the meetings started with a review of the Healthy Oregon Act principles and goals and Healthy Oregon Act description of the components of an accountable health plan. Where those components were reiterated in the meetings, they are indicated in italics.*

** indicates this component was raised in all community meetings.

* indicates this component was raised in most community meetings.

Providers

- a. Choice of providers. **
- b. Access to every type of licensed and certified practitioner (non-allopathic practitioners) *
- c. You can choose both your primary care provider and your specialist.
- d. Providers decide what is best for patients – not administrators.
- e. There should be thresholds for a timely response to need for a specialist appointment.
- f. *Safety net clinics as part of every plan's network.* *
- g. Convenient access to urgent care clinics.
- h. *Nurse advice line.* *
- i. Enrollees should be able to choose their hospital.
- j. Respect for different religious practices.
- k. Include community outreach workers / promotores
- l. No conflict of interest.
- m. *Medical home model.*

* Plans have client advocates / navigators / coaches

- a. Plans have ability and knowledge with responsibility to connect folks to services offered by plan and community support services where they exist.
- b. Provide opportunities for peer to peer support for certain kinds of conditions (mental health, cancer, diabetes, etc).
- c. Plans make very effort to teach people about how to keep folks out of ER
- d. Coach or personal assistance for folks who need help (patient advocacy –case management)
- e. Use promotore model
- f. Plans have outreach teams.

Benefits

- a. Comprehensive: dental, vision, mental health, physical, prescriptions, therapies, hospice care, DME, etc. **
- b. Plans held to services that are evidence based on randomized clinical trials (this was raised in Eugene amongst great discussion around the comment that that most trials are biased from the start).
- c. All plans must offer same benefits. Uniform benefits. **

- n. Non-profit. **
- o. Premiums and out of pocket costs for services are affordable for families of all income levels. **
- p. Services are fairly priced. *
- q. Reimbursement that encourages more primary care providers, preventive care, education
- r. All plans pay providers the same amount for the same services. *
- s. Plans work together to create/support/nurture centers of excellence (as one way of improving quality and controlling unnecessary proliferation / duplication of services)
- t. I can keep the plan as long as I like. (I can take the plan with me.) *
- u. Knows due process
- v. Protect confidentiality of provider – patient relationships. Protect medical records and their confidentiality. *
- w. Plans respect religious differences.
- x. Plans have advance directive process related to family planning/pregnancy termination
- y. Plans have advance directive for end of life care
- z. Plans have process for accepting contributions.
- aa. Cannot terminate patients / enrollees.
- bb. Lets enrollees know what their rights are and where to go with questions / concerns.
- cc. Provides patients with access to their own medical records, copies of what's written. *
- dd. Customer service is measured and recorded.
- ee. Transparency- Provide enrollees/ potential enrollees with comparable information about benefits, costs, and quality.
- ff. All plans should have an advice line.
- gg. Plans should nurture and help teach patient responsibility.
- hh. Reduce administrative overhead including control of CEO salaries. Should be a choice of a locally based plan (these understood to know about and utilize local resources).
- ii. Understand and consider scope of practice: allow for appropriately trained people to do the services they can perform.
- jj. All plans must ensure access locally!
- kk. All plans have standards of care.
- ll. Plans should have limitations on marketing & excess capacity



Investing in Oregon's Health Care Safety Net

**Opportunities
and Challenges**



Safety Net Advisory Council

Staff support – Office of Health Systems Planning (HSP) Office of Health Policy and Research (OHPR)

Members of the Safety Net Advisory Council

Priscilla Lewis, Co-chair – Providence Health Systems

Craig Hostetler, Co-chair – Oregon Primary Care Association

Bill Thorndike – Medford Fabrication

Jackie Rose – Oregon School-based Health Care Network

Tom Fronk – Benton County Health Department

Vanetta Abdellatif – Multnomah County Health Department

Scott Ekblad – Office of Rural Health

Abby Sears – Our Community Health Information Network (OCHIN)

Ron Maurer – State Representative

Beryl Fletcher – Oregon Dental Association

Jim Thompson – Oregon Pharmacy Association

Tracy Gratto – Coalition of Community Health Clinics

Steve Kliewer – Wallowa Valley Center for Health and Wellness

Matt Carlson – Portland State University

Who are Oregon's Health Care Safety Net Providers and what do they do?

Safety Net Providers represent a key building block in a re-engineered health care delivery system

The safety net plays an important role in providing access to primary care for very low-income, uninsured, Medicaid and Medicare clients across the state. By definition, the mission of the "safety net" is to serve those who face a variety of barriers to care including economic, geographic or cultural and racial. As a result, the safety net represents an important element of Oregon's primary care capacity.

In addition to being a key access point for many Oregon's most vulnerable and as a result of their mission - the safety net has valuable, demonstrated expertise in serving these populations and over the past two decades has demonstrated a willingness and ability to innovate and drive transformation in the delivery of care.

Oregon's health care safety net -

- Providing primary care homes
 - for those not yet determined eligible and enrolled in a health plan
 - for those enrolled in a health plan contracting with safety net clinics
 - for those who face barriers to care as noted in the Safety Net definition
- Providing primary care options that fit the needs of certain populations and communities
- Sole providers in isolated rural areas and certain communities
- The delivery system's "insurance" against downturns in the economy
- A laboratory for trying out new approaches to care

Safety Net Advisory Council - Presentation to the Oregon Health Fund Board

Background

Oregon's Health Care Safety Net:

- Federally Qualified Health Centers (FQHC)
- Isolated Rural Health Facilities (IRHF)
- School-based Health Centers (SBHC)
- Community Sponsored Clinics (CSC)
- Local Health Departments (LHD)
- Indian Health Service Clinics (IHSC)
- Hospital Emergency Departments
- Private practices

A Community's Response

Oregon's Health Care Safety Net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous care. Oregon's safety net is comprised of public, private and not-for-profit organizations that provide health care services to uninsured, underinsured and vulnerable persons throughout the state.

Linking these different sectors is a mission or a mandate to provide health care services to people who are in need. Oregon's safety net community shares many strengths and challenges in common but also has a great deal of variation in patients served, revenue sources and business models. Some clinics are private not-for-profit and sponsored by the community; others have some federal funding but can be either not-for-profit or county government operated; still others receive state funds. This complexity presents both flexibility and challenges for policy makers.

A Critical Piece of the Health Care Delivery System

Every day, Oregon's safety net providers have stories to share about people who, without their services, would otherwise go without medically necessary care. Many Oregonians have limited access to primary care and delay seeking help until they are seriously sick or hurt.

Our over-burdened emergency departments have stories to share about patients whose only outlet for medical care is through their doors. These stories describe patients whose conditions could more appropriately be treated in a primary care setting or illnesses and injuries, which could have been prevented or ameliorated if the patient had access to care sooner.

Ideally, the image of a net captures nicely the role of the health care safety net; able to stretch or contract in response to Oregon's economic or health policy climate. In recent years, however, demand for safety net services has risen dramatically requiring the net to expand beyond, in many cases, available resources. Regardless of type or location, safety net providers have stories to share about the challenges they confront with limited resources, increasing demand and escalating health care costs.

This increase in demand is largely driven by the growing number of uninsured individuals or those unable to find a provider willing to receive Medicaid/Medicare reimbursement. However, it is not simply the escalating financial challenges that determines who utilizes Oregon's safety net clinics. Many patients are also struggling with psycho/social barriers. There are a growing number of patients requiring mental health and substance abuse treatment; many are challenged with homelessness or live in geographically isolated areas where access to comprehensive health care services is inadequate.

Oregon's racial and ethnic makeup is becoming increasingly diverse and the safety net serves a disproportionately high percentage of diverse populations as well as individuals living below 200% of the FPL. Safety net providers are seeing greater numbers of patients overall and those patients seeking care are both sicker and are presenting with more complicated conditions.

A Good Investment

If our hospital emergency departments are the "canary in the coal mine" for our health care system, then our safety net clinics help light the way for many who otherwise would not receive the care they need. In addition to responding to this critical need for access to basic health care services, however, Oregon's safety net clinics also serve as laboratories for innovation and experimentation within the delivery system. Care coordination, proactive management of chronic diseases, integration of behavioral and primary care and primary care medical home models have all been launched as pilots within the safety net.

Many safety net clinics are uniquely positioned to redesign the way care is delivered to the populations they serve. These clinics are attuned to the needs of some of the state's most marginalized patients and have developed creative and comprehensive approaches to meeting these needs.

While the safety net has demonstrated itself to be a favorable environment in which to experiment, it is important to ensure that expectations for re-design are compatible with both the needs and the resources of the clinic and the community.

Individualized features of different safety net sectors must be recognized as those that have emerged to best meet the needs of the community. This diversity of sector type, governing structure and financing is both the greatest asset and a confounding element within the safety net – each sector, indeed each clinic, is unique but shares similar challenges with all other safety net clinics across the state.

Because of its range of models, the safety net is complex and difficult to describe uniformly. Nevertheless, it is vital that decision makers utilize a systemic approach for developing supportive policies. Oregon's safety net system is both a critical component of the current system and a place to gain valuable insights on innovative approaches. These lessons can help to inform the process of building a more affordable, effective and sustainable healthcare delivery system for all Oregonians.

The Safety Net Advisory Council advances the following recommendations targeted at **Funding**, **Critical Tools** and **Workforce** as ways to significantly invest in the safety net. Each of these components are linked and will inform the overall stability of Oregon's health care safety net system.

Safety Net Advisory Council

Policy Recommendations

Presented to the Oregon Health Fund Board and the Oregon State Legislative Assembly

1. Stable Funding

Establish the Core Health Safety Net Stability Investment Fund.

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges

2. Critical Tools

Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with the capital-intensive start-up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information and improve the safety, quality and efficiency of care

3. Workforce

Implement innovative approaches to meet safety net workforce needs:

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Services Corps (Loan Repayment)
- Updated Tax Credits
- Provide an increased pipeline of midlevel providers to rural communities.

Policy Recommendation – STABLE FUNDING

Concept Summary:

Establish the Core Health Safety Net Stability Investment Fund.

Establishes a fund to address safety net system needs when there is a statewide downturn in the state and in local economies including but not limited to assisting clinics in financial trouble, making strategic investments to maintain safety net infrastructure, and investing in new sites or expansions where gaps are clearly identified.

This investment fund provides a source of capital in times of need including bridge funding and meeting cash obligations with technical assistance as a component to assist organizations with specific strategies to address underlying issues.

It provides a source of capital for expansion or improvement including facilities expansion or improvement, infrastructure not tied only to economic downturns.

Issue it addresses: *Core safety net providers as defined in SB 329*

- ***Section 2 (2)*** “Core health care safety net provider” means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, and that has a mission or mandate to deliver services.... serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare...

- ***Statement of Principle:***

Section 3 (16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.¹

Rationale

Currently no public fund or financing mechanism exists to help assure this principle is realized. There has been no systemic or statewide investment strategy in the safety net. As a result, the safety net has evolved organically responding to a variety of circumstances across the state over a number of years. This has resulted in both strengths and challenges; the good news is that a network of core providers has evolved to meet the needs of different communities. The challenge is that public policy has limited tools with which to support critical community investment, expand its impact, and to help assure its strength and viability. The Core Health Safety Net Stability Investment Fund would provide such a tool. Recent recession talk and the safety net’s inverted relationship to a downturn in the economy underscores the need for such a tool.

How it would work:

Core Safety Net Investment Model:

- “Grow” investment fund sufficient to provide \$1m in grant funds for year 1, \$2m for year 2, \$3m for year 3 and sustained at \$3m per year

- Fund priority safety net investments from interest
- “Fund” investments also from low interest loans to safety net entities who “repay” revolving loan fund
- Link funds where possible with foundation initiatives to magnify impact
- Include technical assistance role to address issues that are beyond immediate available of cash ie, financial management, business planning, etc.
- Link to matching funds where feasible
- Administered by DHS with necessary expert staffing in house and/or contracted in regard to loan component, guidelines and administrative rules and with oversight by Safety Net Advisory Council with addition of necessary financial expertise
- Or administered by foundation or other independent entity with necessary programmatic and financial skills

Priority Investments:

- Focus on core investments in safety net infrastructure for the provision of primary care, oral and behavioral health
- Identify and assist clinics experiencing financial difficulty
- Identify communities or clinics to establish sites where gaps exist and a feasible long term plan is adopted
- Assistance with recruitment and retention of workforce and/or the use of transformative technology
- Assistance with availability of pharmaceuticals
- Where commitments to providing documentation of outcomes over time are present
- Where matching funds are present
- Where linkages are established with health districts, public health departments, collaboratives, hospitals, other providers, and health systems as appropriate to the location
- Where other existing programs such as tax credits and loan repayment are utilized
- Where commitments to a diverse workforce are present and realized within the limitations of location

Building The Investment Fund - Options for creating the revolving fund include but are not limited to:

- Legislative appropriation
- Public bond
- Partnership between foundations, community funds, health systems, and insurers, and state with contribution to retire bond or establish fund

- Model “adoption” process whereby insurers and health systems adopt sites or clinics for a limited time period to assist them in repaying loans

Anticipated outcomes:

Greater financial stability for the safety net as a whole and in specific communities. Improved safety net ability to respond to changes in the economy. Gaps in the safety net addressed. Improved core infrastructure among safety net clinics. Shared responsibility across key stakeholders and communities. Stronger component of the roadmap.

Cost and how it might be financed:

“Grow” investment fund sufficient to provide \$1m in grant funds for year 1, \$2m for year 2, \$3 for year 3. In addition loans would be made once the fund was sufficiently established. Investing at this level would make a significant difference in the stability and viability of the safety net over time. Expertise in modeling the size of the fund necessary to achieve this rate of grant and loan allocation is needed.

ⁱ Enrolled Senate Bill 329 – 74th Oregon Legislative Assembly – 2007 Regular Session

Policy Recommendation – CRITICAL INFRASTRUCTURE TOOLS**Concept Summary: ***

Address *barriers to safety net electronic health record adoption*. Provides alternative mechanisms to fund and assure high safety net adoption rate and optimum application of electronic health technology. This recommendation proposes *three possible strategies*. They may be adopted individually or in combination. They include an Electronic Health Record fund established by legislative appropriation, state and federal partnership, adoption of a shared cost or utility like model to cover adoption and maintenance. This approach will improve quality of care; provide better information for providers and treatment for patients, greater efficiency and coordination across the delivery system and improved ability to monitor public health.

Background:

With the passage of Senate Bill 329 Oregon committed itself to assuring access and coverage to Oregonians and to reforming the delivery system to help assure access, quality, and safety as well as controlling the rate of cost. There is growing conjunction of federal policy and emerging state policy regarding Health Information technology. There is developing federal policy regarding standards for interoperability and both a state and federal focus on privacy issues.

Oregon has recently been presented with two significant opportunities to develop the necessary health information technology infrastructure. The state received over \$5 million through the Oregon Medicaid Transformation Grant to develop a personal health record model for the Medicaid population. Additionally, Oregon was awarded over \$20 million by the FCC to fully implement broadband connectivity for rural areas.

In essence the message is clear – Oregon and the nation are moving toward greater readiness to implement health information technology as a key tool to serve the broader goals of access, quality, safety, improved health and cost reduction. *The safety net has a key role to play in each of these initiatives and policy makers can assure it has the necessary resources to do so.*

It must be underscored that while this is new territory for most, it is particularly unfamiliar to many safety net providers. Furthermore, there is no way to ensure that the investment will be no-risk or even low-risk to begin with. Health information technology is capital intensive and will require both a significant investment up front as well as on-going technical support.

* *A note on workforce* – it is clear that we need an “e” workforce to go along with e-health technology and its associated implications for clinical practice if we are to realize the promise of health information technology. *It is recommended that the Oregon Health Workforce Institute assess the state of e-health related needs* and work with education institutions and employers, to assure the availability of individuals with necessary skills, certifications, and degrees.

The Safety Net Advisory Council strongly urges the state to engage expert analysis of the electronic health record/personal health record funding options to review the literature and assist with developing the most viable funding option. With that caveat, the SNAC suggests the following alternate approaches.

Summary of Alternative Funding Strategies: (Consider and adopt singly or in combination)

- Create a *safety net EHR investment fund* through a legislative appropriation matched by local collaboratives, health systems, and insurers sufficient to capitalize an 80% safety net adoption rate. Also include low interest loans, revolving loan fund for future adopters, initial pay for performance steps
- *State and federal partnership* leveraging Medicaid and Medicare dollars to invest in clinic network models to bring down cost and support adoption through volume purchasing, subsidies for acquisition, and integrated quality improvement and patient safety strategies
- Define an *Oregon style “utility” model* for funding the cost of EHR adoption, beginning with the safety net and expanding to other parts of the health system. Incorporate technical assistance, quality improvement, patient safety, and primary care renewal elements.

Rationale:

- **Across all providers** – hospitals ahead of curve, health systems clinics 52.2% adoption rate, solo clinician practices 19.3%, 2-4 clinicians 25.1%
- **Safety net** – Public and FQHC clinics (20.4%)
- by each safety net sector – FQHCs 29.6%, SBHC in Public category 20.4%, RHCs likely less than 15% (arbitrary percentage)
- Churning of individuals on and off Medicaid and across health plans and providers
- the need for more systematic approaches to comprehensive EHR adoption
- Government, federal, state, and sometimes local obtain and/or leverages resources for those providers without the margin to invest
- Important to identify critical criteria for a comprehensive funding strategy
- Potential for some strategies to help facilitate adoption across the entire system
- Some resources and solutions unique to the safety net are needed

Safety Net:

- Includes school based health centers (SBHC), Federally Qualified Health Centers (FQHCs) (otherwise known as Community Health Centers), Rural Health Clinics especially those known as Isolated Rural Health Centers (IRHC), and volunteer clinics

- Together these clinics provide services to the uninsured and represent a significant part of Medicaid capacity
- Increasingly a larger percentage of Medicare clients, with the exception of SHBCs, will be seen by those clinics who currently comprise the core safety net
- While the primary emphasis of this analysis and recommendations is on the core safety net it is important to recognize that many small to medium offices also provide some level of care to a similar population
- Some EHR solutions or strategies may be focused on the core safety entirely or in other cases scale may suggest integrated solutions across a broader portion of primary care

Barriers to adoption:

- **Across all providers** – initial system cost, initial temporary productivity loss, risk of failure, ongoing cost, confusing array of products, lack of expertise, ok with the way it is, someone needs to lead the charge
- Lack of state HIT roadmap “target end-state architecture vision – in process but not at “use” stage
- **Safety net specific** – Generally similar especially regarding cost and productivity loss but with much less income and operating margin than private sector, less access to capital
- Without the same ability to generate additional margin, safety net provider funding strategies involve financing EHR through reduced services to uninsured Oregonians
- Within the safety net, not all “lines of business” are equal: – FQHCs (and associated SBHCs) have the greatest exposure to EHR through OCHIN (an Oregon based clinic controlled network); SBHCs not associated with FQHCs have limited exposure and resources. RHCs especially isolated rural ones are concerned with the full range of barriers and limited time and resources to attend to EHR. Volunteer and free clinics, in addition to other barriers may face the challenge of recruiting additional volunteer and in-kind resources to maintain an EHR. In addition, ability to adopt inversely related to percentage of uninsured clients served.

Current approaches to funding

- **Across all providers** – self-finance from profit or operating margin, loans
- **Safety Net** – federal and foundation grants, capital fund drives, loans, county general fund (for those that are also FQHCs), collaborative approaches such as OCHIN, reducing capacity to serve
- Federal grants relating to HIT adoption
- Note limitations of grants
- Note uneven resources and fragmented strategies across the safety net
- Pay for performance at early formative and explorative stages
- Lack of incentives slows adoption rate across all primary care

Cost and Potential Financing

Suggested criteria for consideration of options:

- Broad based stakeholder participation – purchaser, insurer, consumer
- Approach addresses needed changes in clinical practice to assure optimum outcomes from EHR implementation
- Targets penetration percentage across safety net and primary care
- Linkages to other EHR related initiatives are established
- Provides key elements for systemic solution
- Provides solutions that may be applied retroactively, to include early adopters
- Not overly complex
- EHR products are certified
- Concepts include technical assistance for EHR selection
- Concepts provide technical assistance for optimizing EHR utilization
- EHR selection and implementation is closely linked to clinicians and evidence based clinical practice
- Concepts assure EHR is integrated into quality improvement and patient safety practice
- Concepts assure Rural EHR network capacity across large rural areas of the state and multiple small clinics

Alternative Funding Approaches:

A. Safety net EHR fund

- State incentive package or menu including grants, low interest loans, revolving loan fund for future adopters, initial pay for performance steps
- Cost for 80% safety net adoption rate over 2 years estimated
- Cost burden is shared by state general funds, purchasers/insurers/health systems share, and local partners share
- Legislature appropriates EHR Safety Net adoption fund
- Other purchasers contribute to grant and/or loan pools
- First priority for grants for isolated rural areas and other entities with very limited access to capital
- Minimum requirements for access to fund determined including pay for performance indicators
- Grants and loans fund amount based on loans sufficient to accomplish desired adoption rate
- No interest loan repayment over 5 years for individual adopters using the loan component

B. State and Federal partnership

- DHS/CMS/HRSA partner to model integrated safety net EHR funding strategy. Per member per month cost is determined for Medicaid and uninsured individuals and partners share cost proportionately, Medicaid for Medicaid, and DHS and HRSA for uninsured. Incorporating set of expectations for quality improvement and EHR adoption, e.g. use of health center controlled networks and/or application service providers could be additional elements of such collaboration – See HHS description of demonstration using Medicare wavier authority as a potential model for Medicaid.
(http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/EHR_Summary.pdf)
- Partners set adoption target and primary care renewal related targets
- Partners establish leveraging linkages between Medicaid Program, Medicare Program, Medicaid Transformation Grant, FTC grant, and Intergovernmental Transfers, alternatives to PPS, or other mechanisms
- Identify statewide infrastructure to facilitate EHR adoption and maximize benefit of group purchasing such as health center controlled networks and/or application service providers to bring down cost and support adoption through volume purchasing, subsidies for acquisition, implementation assistance, and integrated quality improvement and patient safety strategies

C. Oregon EHR Utility

Key principle – access to and funding for electronic health technology could be on a basis similar to water, fuel, and other similar resources needed by the public at large

- Elements common to utility services, according to M.A.Rappa* include necessity, reliability, usability, utilization, scalability and exclusivity although in various public models exclusivity may be not be utilized in favor of a more competitive arrangement.
- utility operates and maintains access to the needed resource and distributes cost across all “users” including initial implementation and ongoing costs or only initial implementation costs
- The ultimate beneficiaries are low income and uninsured Oregonians. In this model stakeholders act on their behalf providing the initial necessary capital with both the stakeholders and patients deriving benefit
- Concept is scalable to the safety net and based on success could be expanded to include all 2-10 person offices, and beyond that to all health systems

C(i) Utility Adoption Goals

- Statewide goal could be set 80% of all core safety net providers and/or broader Medicaid primary care adoption of EHR within 2 years
- Implementation costs for 80% safety net adoption rate within 2 years can be estimated at _____.
- Implementation costs for 80% adoption by all Medicaid providers within 2 years can be estimated at _____.

C(ii) Utility Core Structure

- Initial capital fund financed by a commercial bank – at XX dollars
- Entity selected to manage distributed payments and services payments on line of credit
- Cost is distributed across Medicaid, Medicare (?), private insurers, and clinics on a per person per month basis including costs for the uninsured
- All funding entities participate in governance body (non profit or semi-independent stage agency, e.g. EHR commission?)
- Patients/consumers also participate on governance body
- Initial capital acquisition costs distributed over 5 year pay-off period?
- Entity provides group of EHR transformation services including technical assistance at implementation, implementation and optimization of primary care home care management elements and related patient safety and quality improvement elements.
- Participating providers agree to implement A Certification Commission for Healthcare Information Technology (CCHIT) certified EHR
- Participating providers agree to adopt and implement quality measures as determined by project governance
- Initial focus on safety net then expansion to all primary care
- Safety Net to goal adoption cost estimate and utility related income estimate needed
- Medicaid to goal adoption cost estimate and utility related income estimate needed

Anticipated outcomes of EHR adoption:

- “The driving force for adopting advanced health information technologies is the potential it provides for improving the quality and safety of health care.” From a report produced by Office of Health Policy and Research in 2007 **Potential Impact of Wide spread Adoption of Health Information Technologies on Oregon Health Expenditures**
- “The net potential savings in Oregon from the widespread adoption of advanced health information technologies are between \$1.0 and \$1.3 billion annually. This level of savings would yield a net reduction of 4.3% to 5.9% on Oregon’s health expenditures. Such savings are possible within 12 years with aggressive implementation efforts.”
- “For uninsured patients the payers are predominantly the physicians, **safety net clinics** and hospitals that end up financing the uncompensated care they provide. When services are avoided, the costs of uncompensated care rendered to the uninsured absorbed by physicians, hospitals and other providers would be lower.”
- **Policy makers** – data to make good policy, less cost, greater value
- Good products combined with good practice, quality improvement, safety, and technical assistance leads to:
- **Patients** – better care, safer more affordable care, and information on their care

- **Providers-** patient and treatment information when needed and greater capacity to manage care on behalf of their patients
- Create the groundwork enabling movement of patient information between providers (**Health Information Exchange**)
- **Public health** – monitoring and improving population health

Policy Recommendation WORKFORCE

Concept Summary:

Rural Locum Tenens Program*

Public Policy Goals:

1. Provide temporary coverage to rural healthcare providers during vacations and continuing medical education
2. Sustain medical and dental service delivery when local providers are away from their respective rural communities
3. Provide longer term medical and dental services to rural communities without medical care services or those that have lost medical care services
4. Expose medical residents and OHSU faculty to the realities and opportunities of rural medical and dental practice

Taken from the Latin “to substitute for”, locum tenens providers are physicians who provide temporary medical services for a specific length of time. This can vary from a few days to allow for vacation or continuing medical education, to several months for medical leave or interim coverage between providers.

The Rural Locum Tenens Program seeks to assist rural communities, physicians and dentists by providing reasonably priced, high quality, reliable relief coverage so that these providers may have time away from their practices for continuing education, vacation, health or other personal reasons or family time. In addition this model may provide longer-term services to communities without medical or dental care and may be linked to supervision of mid level networks in certain areas of the state.

Issue it addresses:

Multiple factors jeopardize adequate healthcare coverage for rural communities in Oregon and nationwide.

- Inadequate number of medical and dental school positions (Oregon and nationally)
- Inadequate number of residency positions (Oregon)
- Declining enrollment of students from rural backgrounds (nationally, somewhat less so in Oregon)
- Declining student interest in primary care specialties (nationally, less so in Oregon but still a problem)
 - Rapidly rising debt load limits interest in lower paying specialties and areas among health profession students (medical, nursing, allied health)
 - Low reimbursement rates for primary care specialties
 - Admissions policies that favor students unlikely to go into rural practice

* Concept initially developed by a work group of the Oregon Health Workforce Institute – SNAC is appreciative of their effort

- Declining state support for the public and education missions of OHSU (Oregon is 45th out of 48 in per student funding among medical schools who receive public funding)
- Changing demographic of medical school graduates
 - Approaching 50% women
 - More dual career families (w/spouse needing to be in urban area for job)
 - Trend toward medical careers with less call, more scheduled hours
 - Less willingness to commit to long-term practice location
 - Increased number of job changes over career
 - More employed physicians, no desire to run a small business
- Rural physician population older than urban population
- Rural population older, and aging faster than urban
- More dependent on Medicaid/Medicare, more uninsured in rural leading to reduced reimbursement and marginal profitability of rural practices
- Vulnerable infrastructure in rural communities (schools, social, economic)
- Inadequate loan reimbursement/forgiveness opportunities

Due to these and other factors, attracting physicians and dentists to live and practice in rural communities is getting harder. Graduating physicians find they can have less call, better income, and better opportunities for spouse and children by choosing non-primary care, urban jobs. This is compounded by the increased workload that then falls to those who do choose to go to rural areas.

Rural practices and hospitals have difficulty covering the needs of their community on a 24 hour, 7-day per week basis due to the limited numbers of providers present in the community. Many rural communities do not have sufficient medical staff to allow physicians or dentists time away for vacation, continuing education and other important activities to prevent burnout and increased turnover. In addition, the broad scope of practice inherent in rural practice can make finding temporary coverage difficult or prohibitively expensive. Commercial locum tenens agencies charge fees substantially higher than can be afforded by rural physicians, whose incomes and practice revenues are not sufficient to support those costs.

How it would work:

Utilizing OHSU faculty, fellows and residents will make available a high quality, well-trained workforce for rural communities; provide coverage at a lower cost with broader scope of practice than is often available from commercial sources. Benefits to OHSU and the faculty are enhanced practice opportunity and maintenance of skills for participants, additional income opportunity to departments and physicians, and the opportunity for young physicians and dentists to experience rural life and practice without an initial full-time commitment (which may enhance recruitment opportunities for these communities).

As the only current academic health center in Oregon, OHSU holds much of the responsibility for training physicians and dentists to meet the needs of all Oregonians. Faculty, fellows and residents can participate as locum tenens providers on a part-time

temporary basis as part of their regular duties, or as extra income producing work. Because OHSU already verifies credentials of its physicians, communities do not sustain any extra expense to perform these essential tasks. Academic health center based programs exist in other areas, such as University of Kansas and University of New Mexico.

Anticipated outcomes:

For rural physicians and dentists:

- Affordable practice relief for vacation, continuing education or illness
- Supplemental assistance during busy times
- Ability to keep office open and staff employed
- Revenue produced when office would otherwise be closed
- Recruitment

For locum tenens physicians and dentists:

- Opportunity to experience rural practice without having to commit long term to one location
- Income to relieve financial burden
- Skill enhancement
- Flexible scheduling and part-time work availability

For rural communities:

- Ability to obtain 24 hour/7 day medical services
- Recruitment
- Economic development, keeping medical care in the community
- Opportunity to showcase community to potential physicians and dentists.
- Infrastructure development

For OHSU:

- Support for rural communities
- Training opportunities for faculty, fellows and residents
- Academic faculty skill enhancement and maintenance
- Support for community physicians who provide teaching service to OHSU

Cost and how it might be financed* :

Fees generated by the program will provide the majority of the funding. To keep fees low enough to be helpful, however, there is a need for additional support. The Area Health Education Center at OHSU received grant funding for program planning and development. Additional funds will be sought from the Legislature for start up costs, administrative overhead, and technical assistance for communities seeking locum tenens services. Funds will also be sought to provide a program subsidy for services provided in medically underserved areas. These funds, if obtained, can be used to sustain the first 2-3 years of start up for the program. A sliding scale fee will be developed in order to keep the costs low enough to be feasible.

* These cost projections were undertaken prior to the inclusion of dentists into the locum tenens program and will need to be re-thought to incorporate this addition.

The start-up costs for a locum tenens program at OHSU would be \$1 million for the first biennium. On-going funding will decrease once the program is up and running as fees and revenues generated by the provision of medical services will offset most program costs. There will likely be the need for \$500,000 of state funding per biennium to subsidize locum tenens services to communities that cannot cover the costs (e.g. rural communities with no local hospital).

Concept Summary:*

Support of Physician Assistants and Nurse Practitioners to Meet the Rural Primary Care Medical Needs of Rural Oregon

Public Policy Goals:

1. Recognize the reality that the limited present and future supply of primary care physicians will have added adverse impact to rural Oregonians.
2. Provide an increased pipeline of physician assistants and nurse practitioners educated to provide primary care services in rural communities.
3. Due to the shorter length of training, be able to quickly increase the supply of qualified primary care providers for rural communities.
4. Utilize existing public health or other community infrastructure to provide a "home" for supervising physicians
5. Link effort to achieving specific health outcomes through training of mid-levels in integrated primary care and public health approaches

Provide targeted investments in existing physician assistant and nurse practitioner educational programs to provide incentives for the recruitment of students from rural areas through pre-awarded loan forgiveness (pending successful completion of the training program) and expanded rural rotations for these and other students.

Provide incentive funds for local health departments or other entities to hire a physician, supporting up to four to eight physician assistants that would serve the more remote parts of the participating counties or regions. Physician assistants are a good fit for remote, low population communities that are unable to attract or support a physician. If two or more counties partnered in such an arrangement it would likely be more sustainable over time. This local network concept could entertain other partners such as rural hospitals to help spread the cost and contribute to sustainability. Formation or utilization of an existing health district might provide a framework for this relationship.

This employment arrangement may also relieve the burden of cost of the physician's malpractice coverage, as s/he would be the employee of a public agency. Note: Tort Liability situation is up in the air as the result of the recent State Supreme Court decision

* Note: This concept was originally developed by a rural health work group of the Oregon Health Workforce Institute (OHWI). It has been modified in some ways to further clarify the concept. The Safety Net Advisory Council appreciates the OHWI commitment to developing ideas to address workforce needs.

that the tort liability cap is too low. This is an issue that will have to be addressed and is broader in implication than this particular proposal.

While nurse practitioners and certified nurse midwives do not require the supervision of a physician in order to practice in Oregon, that supervision is required to comply with federal Rural Health Clinic (RHC) regulations. The same arrangement could be utilized for nurse practitioners and certified nurse midwives working in rural health clinics. Similar partnerships to those noted above in regard to physician assistants could be developed. The health district model could facilitate a regional approach to addressing rural workforce needs.

This model could be further developed to link the work of community health workers, community paramedics and public nurses into a coordinated team to assure the provision of necessary care and health promotion and preventive services.

Issue it addresses:

This concept would address the economic challenges faced by rural areas of the state in providing for health and healthcare related services. It would help address some of the challenges faced by rural health care and rural public health.

Oregon has been one of the national leaders in the training, licensure and deployment of physician assistants and nurse practitioners. Presently approximately 650 physician assistants are licensed in Oregon. Of these, approximately 300 practice in primary care throughout the state, one-third of who are working in the Portland metropolitan area. There are presently approximately 2,750 advanced licensed nurses (nurse practitioners, certified nurse midwives, Certified Registered Nurse Anesthetists) actively licensed in Oregon.

Several national trends indicate a future significant shortage of primary care physicians:

1. Inadequate numbers of medical students in the educational pipeline to meet the projected needs of a growing and aging population and to replace physicians who will retire in the coming ten years.
2. Fewer and fewer medical students choosing primary care specialties due to many causes such as lower income and demanding life style.
3. The time lag of at least 8 years (four years of medical school and four years of residency) to add additional primary care physicians.

Communities often shy away from considering physician assistants due to the additional cost of the supervising physician.

How it would work:

- County wide or multiple county public health commitment is made to provide the home for network supervision
- Similar commitments are made if rural clinic, rural hospital or other entities commit to network supervision

- Entity partners with educational institutions to provide options for rural rotations and other approaches to enhance the likelihood of placement in their communities and education program target is established
- Educational institutions recruit and enroll
- Area Health Education Centers participate through health career approaches at the elementary and secondary level
- Office of Rural Health links loan repayment program to students at beginning of program and monitors relationship
- Steering committee comprised of stakeholders provides a home for the overall strategic partnership
- Effort is evaluated by external parties against predetermined outcome indicators

Cost and how it might be financed:

1. Legislature provides targeted investment appropriation to existing physician assistant and nurse practitioner educational programs to facilitate the recruitment of students from rural areas and to expand rural rotations.
2. Funds are added to loan repayment program to address commitment provided to recruited students

<http://www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/providers/upload/loan-repayment-faq.pdf>

3. Legislature provides matching implementation funds to encourage local health departments to participate and provide the necessary supervision and coordination
4. The deployment of physician assistants and nurse practitioners to rural communities comes with the added costs of paying for a supervising physician and his/her malpractice exposure costs.
5. Cost is shared by legislature through its appropriation for loans and other incentive costs, public health in-kind and general fund costs or health district revenue, and other community participants
6. State total cost participation is limited to initial four year period and extended another four years pending evaluation activity
7. State participation is front loaded and tapered off over the life of the project with potential longer term commitment limited to education appropriation and incentive funds for new areas of the state
8. Cost categories include loan repayment and/or forgiveness commitments, mid-level supervision, education institution recruitment funds, Area Health Education participation, technical assistance from Office of Rural Health or other sources
9. Cost to be projected

Anticipated outcomes:

- Additional mid-levels would help address rural workforce needs
- Educational institutions would increase the flow of trained mid-levels in the pipeline and would have confidence in the availability of resources to make this happen

- The cost burden would be distributed across more entities and limiting the burden on any single entity
- Effort would be linked to identified health outcome and access indicators

Concept Summary: *

Oregon Health Services Corps (OHSC).

Strengthen Oregon's Recruitment and Retention Tool Chest through the implementation of an Oregon Health Services Corps (building on the existing limited loan repayment program) making it available to the workforce communities the safety net depends on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral and mental health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists. Provide a high level of coordination and integration with other programs addressing workforce needs. This recommendation will provide resources for communities, helping them to compete for available individuals regionally and nationally. This program should be seen as a **companion to the Tax Credit program** described in another recommendation brief. Both programs are part of Oregon's recruitment and retention tool chest.

Public Policy Goals:

Provide a sustainable supply of qualified health professionals to underserved Oregon communities to maintain and improve the health of the community while contributing to economic development.

Issue it addresses:

The loan program was originally created in 1989 although awards were not made until 1994. Since then 122 health professionals have been awarded loan repayment. Of the 122 38% are physicians, 38% are nurse practitioners, 22% physician assistants and 2% are pharmacists (added in 2005). Dentists were added to the program in 2007; the first opportunity for a dentist to be awarded loan repayment will be in 2008. Of the 122 awardees, 20% are currently receiving payment and 38% have fulfilled their obligation and completed the program and 42% either declined or forfeited their award. **Funding remains at \$400,000 per biennium**, the level originally appropriated in 1989 **and** with the additional eligible professions added.

Given projected workforce needs the amount appropriated, the amount available for each health professional, and the range of health professionals included is insufficient to attract the range of workforce needed. Loan repayment and related support services are not generally available to other necessary parts of the workforce. That includes behavioral health practitioners other than those covered above and dental hygienists.

* Note: This concept follows closely but not exactly recommendations developed by a Rural Health Policy Work Group staff by the Oregon Health Workforce Institute. The Council appreciates the work of this group and its focus on an area of critical need.

The federal government makes loans and scholarships available through the National Health Services Corps. Physicians, nurse practitioners, physician assistants, dentists, mental and behavioral health professionals, certified nurse midwives, and dental hygienists are eligible for loan repayment or a limited number of scholarships based on practice site scores. They must agree to serve in underserved areas and fulfill a minimum service commitment. Currently Oregon has about 60 practitioners who benefit from this program. Federal funds are limited and must be distributed across the 50 states. Available loans are far fewer than the need nationally and locally. It is an important resource for Oregon but is limited in its ability to meet Oregon's needs.

How it would work:

Eligibility: Similar to Oregon's current program but adding mental health professionals and dental hygienists. While the workforce shortages in rural communities are especially critical and require prioritization, there should be the potential for adding eligibility for certain high need urban areas based on poverty level, health disparities, and other indicators once the rural program is adequately and sustainably funded. This determination should be undertaken in consultation with the Office of Rural Health, Office of Health Policy and Research and Department of Human Services.

Program Parameters: Similar to current LRP. Potentially extend years and total eligibility amount. Target an actual number of loan repayers based on projected size of rural network we would like to sustain. Loan repayment can be pegged at 80% covered equally over four years and the remaining 20% as a bonus for an additional two years of service in a designated underserved area.

Penalties/Enforcing Provisions: Current LRP

Evaluation/Monitoring: Use Return on Investment (ROI) methodology to determine whole community benefit: calculate number of patients seen; determine retention rates (including how many remain in the same location and how many continue to serve underserved populations); obtain feedback from sites, communities and students. Provide data on outcomes to the Oregon Health Workforce Institute (OHWI). Secure OHWI participation in evaluation activities.

Administration: Office of Rural Health (stronger rural community connection) and/or Oregon Office of Health Systems Planning (HSP) where National Health Service Corps (NHSC) related expertise and coordination resides. The loan repayment administration should remain with the Oregon Student Assistance Commission (OSAC). Additional staffing of at least 1 FTE would be needed to assure the success of this program.

Additional Innovations and Linkages:

- Add robust communication and training component (technical assistance) over and above loan Repayment.
- A truly comprehensive program would include loan forgiveness as well as loan repayment. Loan forgiveness programs make the loans to students, and then

“forgives” repayment of those loans if the newly trained provider practices in identified areas of need. Loan repayment simply grants \$ to be used to pay off student loans regardless of their source. Loan repayment is a short-term strategy; loan forgiveness is a longer-term strategy that enables us to cultivate rural Oregonian health professional students/providers.

- Integrate with clinical practice support resources (locum tenens, telehealth, protocols, rural health outreach, health professional training, Oregon Rural Practice-based Research Network, etc.).
- Link OHSC to Area Health Education Center (AHEC) pipeline activity at the high school level (link loan repayment information to pre-med students, pair students with loan recipients, create high school college- level memberships and other membership categories, etc.). This is in part a “branding” process to build a pipeline of future OHSC and to build sense of belonging to something important.
- Work out a mechanism to provide partial loan repayment to locum tenens providers who work in underserved areas of Oregon.
- Tie OHSCorps as a “community menu option” with strong technical assistance to support deployed practices and encourage provider retention.
- Add community generated incentives to OHSC membership; for example, in order to qualify for state support, a local community may have to provide an in-kind match that could consist of an equipped clinic/office facility, housing for the locum tenens and/or full-time provider and a community board of directors/advisors

Anticipated outcomes:

- Rural Oregon and the safety net is better able to compete with urban areas and other states
- Incentives are sufficient to draw needed professionals to rural areas and to the safety net

Cost and how it might be financed: Legislative appropriation

Assumptions:

Average physician/dentist/pharmacist educational debt = \$130,000

Target 10 new physician/dentist loan repayment candidates per year =

Year 1 = 25% X 80% X 10 =\$260,000

Year 2 = 25% X 80% X 20 =\$520,000

Year 3 = 25% X 80% X 30 =\$780,000

Year 4 = 25% X 80% X 40 =\$1,040,000

Average other health professionals (nurse practitioners, physician assistants, radiographers, etc.) = \$50,000

Target 20 new loan repayment candidates per year

Year 1 = 25% X 80% X 20 =\$200,000

Year 2 = 25% X 80% X 40 =\$400,000

Year 3 = 25% X 80% X 60 =\$600,000

Year 4 = 25% X 80% X 80 =\$800,000

Note: Doesn't yet include costs for behavioral health, dental hygienists, or other providers or any additional staffing costs

Projected Biennial Costs: with additional 1.0 FTE for the ORH and additional 1.0 FTE for OSAC

2009-2011 Biennium: \$1,900,000 (includes some administrative costs)

2011-2013 Biennium: \$ 3,900,000

Concept Summary:

Update Oregon's Tax Credit program

Increase tax credit amounts originally established in 1989 and include additional eligible provider categories to attract and retain the workforce that communities and the safety net depend on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists.

Issue it addresses:

This program was initiated in 1989. Eligible professions include physicians, podiatrists, nurse practitioners, physician assistants, and dentists, EMT's, optometrists and certified registered nurse anesthetists. Practitioners are eligible for up to \$5K/year and most are able to claim the maximum amount. Approximately 1,750 received the benefit last year at an estimated biennial of \$14.6 million. **Maximum per year of tax credit has not been modified** since the beginning of the program. A number of professionals important to rural Oregon and the safety net are not eligible.

How it would work:

The following modifications to the benefit are proposed:

- Increase the tax credit maximum from \$5,000 to \$10,000 per year.
- Broaden eligibility for **dentists** and add provisions to include **behavioral and mental health providers** to the program with proportional tax credits.
- The emergency medical technician (EMT) tax credit should be revised to include **first responders**. Eligibility requirements should be changed so that professional EMTs who also volunteer their services are not excluded. A bill was introduced in the 2007 legislature that did not pass and would have corrected that unintended exclusion.
- Add community paramedics and other community health workers identifying proportional tax credit maximums

Anticipated outcomes:

Rural areas of Oregon and the safety net will be more competitive with urban areas and other states in attracting necessary workforce.

Cost and how it might be financed: Legislature passes bill incorporating changes and appropriating dollars. Impact of changes to tax credit provisions needs to be determined.

Concept Summary:

Flexible Workforce Approaches for Rural Oregon

Build flexible responsive community health infrastructure by establishing multiple community or regional networks and targeting key outcomes. Expand the range of individuals able to provide emergency medical services, treat or assist with treatment of certain acute and chronic conditions, and provide preventive and health promotion services. Provide the necessary education, certification, and clinical oversight. Adopt necessary payer policies. The use of Para-professionals must be fiscally sustainable.

Requires partners co-creating an environment where sufficient individuals are licensed and/or trained and certified and able to do what needs to be done complemented by communities and regions that partner with each other to provide the necessary supporting infrastructure of supervision, coordination, administration, and financing. Local government and public health departments, hospitals, clinics, ambulance companies, local advocates make up the critical mass of energy, experience, and commitment. State government has a role to play as well. Many factors contribute to the success of such partnerships.

- This means focusing on what can be done without physicians, nurse practitioners or physicians assistants *directly* providing = emergency services, certain non-urgent acute care, certain preventive services, health education, care coordination and linking this capacity to necessary and affordable clinical oversight
- Training programs and certifications can enable EMTs to provide certain medical services, preventive services, and health education
- Public health and other nurses can perform this array of activities with additional certification as EMT and depending on the person, training in preventive care and health education and/or can provide some level of coordination of these resources
- Community Health Workers can provide care coordination, case management functions, and health promotion with appropriate training and certification as well as EMT functions in some communities
- Use Community Access Project “Pathways” model to manage toward specific individual health outcomes in support of clinical and public health strategies <http://www.chap-ohio.net/documents/PathwaysManual.pdf>
- Research on community health workers is not deep but some does exist and is suggested of positive outcomes in some areas
- Extensive recent HRSA workforce study provides much information to support design efforts - see <http://bhpr.hrsa.gov/healthworkforce/chw/default.htm#preface>
- Globally and national pilots and models have been implemented or are being designed and provide information to inform design efforts <http://ircp.ncemsi.org/>

- Public health, educational institution, managed care organization and others have shown interest in the development of such models
- State and local public health departments to work together to facilitate analysis regarding prevalence of conditions and risk factors can help target geographic areas and specific populations
- Depending on the communities or regions a clinical team could consist of physician, nurse practitioner, public health nurse, EMT/community paramedic, and community health worker.
- Specific certifications or combinations of training and licensing would depend on the needs identified, the resources available, and the level of community and regional commitment
- Deployment to specific communities would be based on identified community need
- The administrative “home” could be a public health department, hospital, FQHC, RHC, SBHC, or other mutually agreed upon entity capable of providing administrative support.

Issue it addresses:

Rural areas have limited resources to address a range of health related needs including responding to emergencies, providing routine care, managing chronic disease, and preventing illness and injury. At the same time hospitals and public health resources have been limited for similar economic reasons. Rural communities have responded to these kinds of needs through attempting to recruit and retain the traditional roles of physicians, mid-levels, first responders and emergency medical technicians, and in some cases, public health nurses and other staff, each with their own relatively limited scope of practice or program. The increasing cost of health care makes it ever more challenging to maintain a basic infrastructure for health and healthcare in rural and isolated areas of the state. A vital and healthy rural Oregon helps assure a higher quality of life for all Oregonians.

How it would work:

Provide initial grants for up to 4 multi-county and/or multi-community pilots:

- Maintain commitment for minimum of 4 years
- Applicants must include support or participation of local health departments, community collaboratives, AHEC, RHCs, critical access, A, B, hospitals, FQHCs, SBHC, volunteer clinics, EMS providers as relevant
- Community or other educational institutions participate and provide necessary training and certification
- Year 1 state provides 80% grant, year 2 - 60%, year 3 - 50% year 4 - 40% year 5 and on maximum state participation 30%
- Maximum ongoing state participation 50% if health district or other similar mechanism established and maintained or the area is isolated and rural
- Progress assessment at the end of each year, two year preliminary outcome assessment and four years evaluation
- If evaluation is positive existing commitments are maintained and new areas selected

- Options for administration include DHS, Local Public Health Departments, Office of Rural Health, Higher Education or a combination.
- Evaluation could utilize community based participatory research models
- Potential partnership with Oregon Rural Practice Based Research Network
<http://www.ohsu.edu/orprn/>

Anticipated outcomes:

- Use of more expensive and difficult to recruit physicians are used to optimal benefit coordinating the delivery of care across rural areas of Oregon
- Local healthcare and public health resources are more effectively utilized to create desired health outcomes
- More options for local residents to earn a living and contribute to their communities are created
- The needs of Oregon's rural communities and the resources of higher education are more effectively aligned to mutual benefit

Cost and how it might be financed: Through legislative appropriation. Model cost would decline over time to minimum state subsidy level. If successful at achieving outcomes model could be expanded to other areas of the state. See above.

Ball Park Estimated Cost to Imply Order of Magnitude

- \$2,000,000 year 1
- \$1,500,000 year 2
- \$1,000,000 year 3
- \$1,000,000 year 4
- 4 year total = \$5,000,000

Cost elements include:

- Staffing cost depending on mix
- Staffing cost depends on existing mix
- Curriculum and instruction
- Clinical supervision
- Locum tenens as needed
- Travel
- Higher education related
- Assessment and evaluation
- Administration
- Insurance
- Facility related

Investing in Oregon's Health Care Safety Net

Opportunities and
Challenges



Safety Net Advisory Council (SNAC)

Staff support – Office of Health Systems Planning (HSP) Office of Health Policy and Research (OHPR)

Members of the Safety Net Advisory Council

Priscilla Lewis, Co-chair – Providence Health Systems

Craig Hostetler, Co-chair – Oregon Primary Care Association

Bill Thorndike – Medford Fabrication

Jackie Rose – Oregon School-based Health Care Network

Tom Fronk – Benton County Health Department

Vanetta Abdellatif – Multnomah County Health Department

Scott Ekblad – Office of Rural Health

Abby Sears – Our Community Health Information Network (OCHIN)

Ron Maurer – State Representative

Beryl Fletcher – Oregon Dental Association

Jim Thompson – Oregon Pharmacy Association

Tracy Gratto – Coalition of Community Health Clinics

Steve Kliewer – Wallowa Valley Center for Health and Wellness

Matt Carlson – Portland State University

History of SNAC

National Governor's Association Grant - 2004

Convened broad-based expert workgroup and developed report '*Enhancing the Safety Net through Data Driven Policy*'

- Governor endorsed report and recommendations – SNAC formed 2005
- Primary staff support through Division of Public Health, Office of Health Systems Planning, in partnership with Office of Health Policy and Research, Division of Finance, Policy and Analysis and Division of Medical Assistance Programs

SNAC's CHARGE

- *The Safety Net Advisory Council (SNAC) provides the Governor, the Director of DHS, the OHPR Administrator, the Oregon Health Fund Board, the Oregon Health Policy Commission (OHPC) and the Medicaid Advisory Committee (MAC) with specific policy recommendations for the provision of safety net services for vulnerable populations who experience barriers to accessing care.*

What is the Health Care Safety Net?

“The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.”

Enrolled Senate Bill 329 – 74th Oregon Legislative Assembly – 2007 Regular Session

Patients the Safety Net Serves

- Populations Experiencing Significant Barriers to Accessing Care (financial barriers only one of many)
 - Cultural
 - Language
 - Transportation
 - Geographic
 - Homeless
 - Higher prevalence of mental illness
 - Substance abuse, including meth addicts
 - Cognitive impairment/ memory problems
 - Decreased functional status
 - Health literacy barriers
 - Socially isolated
 - Financial

Safety Net Defined — SB 329 74th Legislative Assembly

Providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. “Safety net providers” includes health care safety net providers, **core health care safety net** providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

Safety Net Providers with the Mission to Serve Vulnerable Populations

- . Persons who experience significant barriers to accessing health care
 - . Homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance, and financial barriers
 - . A mission or mandate to deliver services to persons who experience barriers to accessing care
- Serving a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

A community's response

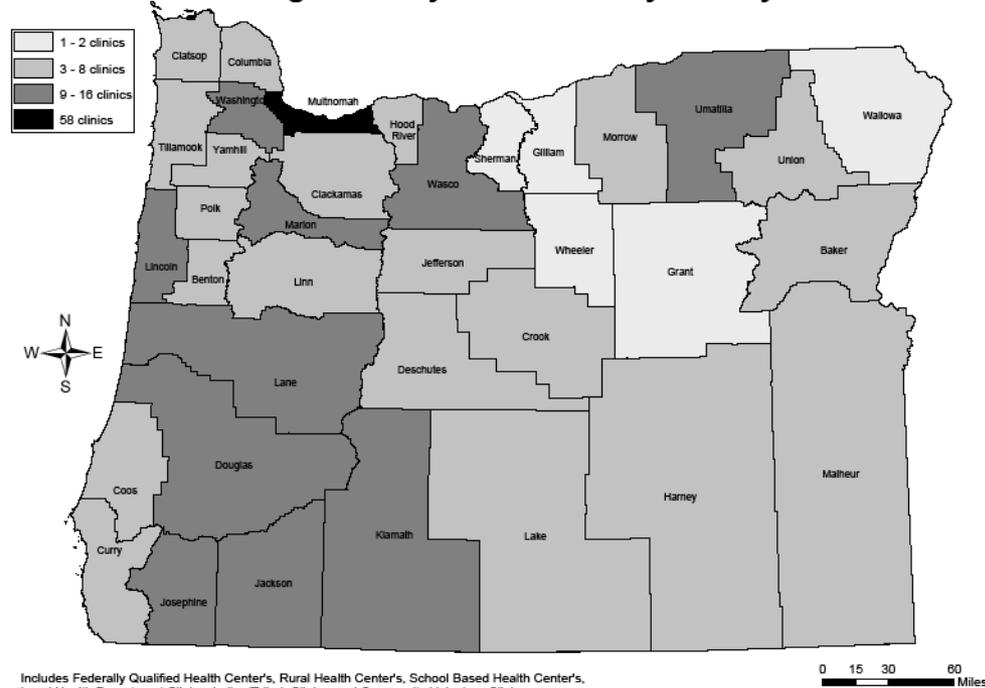
- Federally Qualified Health Centers – or Community Health Centers
- School-based Health Centers
- Isolated Rural Health Facilities
- Community Sponsored Clinics
- Hospital Emergency Departments
- Local Health Departments
- Tribal Health Clinics

Safety Net Clinics

- **School-based Health Centers** - currently 45 centers in 19 counties
- **Isolated Rural Health Facilities** – currently 17 facilities in 14 counties
- **Federally Qualified Health Centers** - 26 centers with over 150 sites located in 27 counties
- **Community Sponsored Clinics** - (approximate) 14 clinics in 6 counties
- **Tribal Health Clinics** – 10 Clinics in 9 counties

Safety Net Clinics in Oregon

Oregon Safety Net Clinics By County

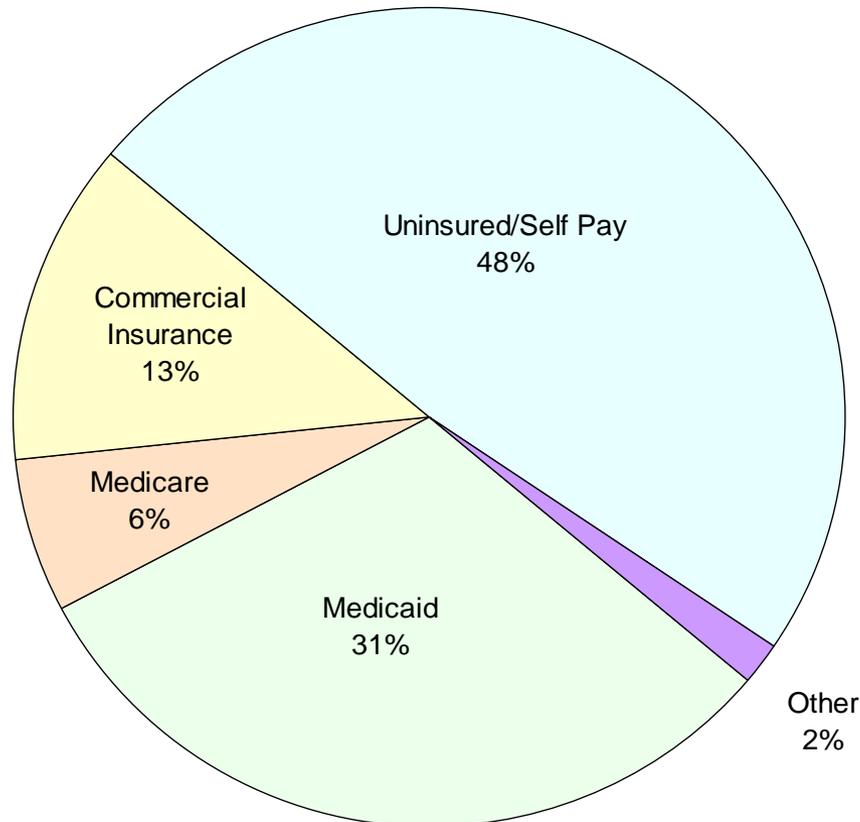


Includes Federally Qualified Health Center's, Rural Health Center's, School Based Health Center's, Local Health Department Clinics, Indian/Tribal, Clinics, and Community Volunteer Clinics.

Prepared By: ORDHS, Health Systems Planning, 1/10/08

Percent of Patients by Insurance status – (All safety net clinics – SNAC core data)

Patients By Insurance Status: All Safety Net Clinics



Numbers of Patients by Insurance Status

(All Safety Net Clinics, SNAC core data)

- Medicaid – 83,957
- Medicare – 16,772
- Commercial Insurance – 34,890
- Uninsured/Self Pay – 130,988
- Other – 4,301

- **Total – 270,908**

Types of Services Offered

Type of Services and Intensity Varies Across Safety Net

- Primary and acute care
- Urgent and emergent care
- Mental and behavioral health
- Dental health
- Chronic Care Management
- Interpretation services
- Care Coordination/delivery system navigation
- Referrals to other supportive services
- Transportation

What we don't (but **NEED**) to know

- Data gaps across the safety net
- We know more about some sectors of the safety net than others*.
- Areas of Need:
 - Hospital ED patient visits for safety net patients statewide
 - Better data on where workforce gaps are, particularly for midlevel providers and ancillary staff
 - Uniform measures, where appropriate, across the system
- A more detailed data set forthcoming and SNAC will continue to work on data gaps

* OCHIN has a sub-set of FQHC's with robust data. A demonstrable benefit of Health Information Technology

Safety Net Advisory Council's Recommendations

- STABLE FUNDING
- CRITICAL INFRASTRUCTURE/
TOOLS
- WORKFORCE

Essential Building Blocks

- There is currently no public fund or financing mechanism to support the safety net. An Investment Fund would support community investment, expand safety net impact and help to assure its strength and viability
- Oregon and the nation are moving toward greater readiness to implement Health Information Technology to improve access, quality, safety and efficiency. The safety net has a role to play but needs assistance with broad-based adoption
- Safety net providers and rural providers in particular, struggle with recruitment, retention and distribution of the health care workforce. Creative and flexible strategies are necessary to fill these gaps.

Recommendations

STABLE FUNDING...

Establish the Safety Net Integrity Fund

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges
- Fund expansions of RX assistance programs
- Fund dental and behavioral service expansion

Critical Investment

“Grow” an investment fund over a 3-year period sustained at \$ 3 million per year.

Options for Funding:

- Legislative appropriation
- Public Bond
- Public-Private partnerships
- “Clinic Adoption” model

Recommendations

INFRASTRUCTURE/TOOLS

Support Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with capital-intensive start up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information. Improve the safety, quality and efficiency of care

Critical Investment

Options for Funding:

- Safety Net EHR Investment Fund – legislative appropriation
- State and Federal Partnership – leveraging Medicaid and Medicare \$
- Oregon Style “Utility” - modeled after utility services framework

Recommendations

WORKFORCE

Implement innovative approaches to meet safety net workforce needs

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Service Corps (Loan Repayment)
- Updated Tax Credits
- Provide an increased pipeline of midlevel providers to rural communities

Critical Investment

- **Rural Locum Tenens** – fees, grant funding, legislative appropriation
- **Oregon Health Service Corps** – legislative appropriation
- **Updated Tax credits** – Legislative appropriation
- **Increase Pipeline for Midlevel practitioners** – legislative appropriation, public-private cost-sharing
- **Flexible Workforce Approaches** – Legislative appropriation to fund grant program

REVIEW of SNAC Recommendations

- Invest in stable funding for Oregon's health care safety net
- Invest in critical infrastructure by supporting adoption of Electronic Health Technology across the safety net
- Invest in recruitment, retention and flexible strategies to grow and sustain the safety net Workforce.

An essential piece of the delivery system

- Access for Oregon's most vulnerable patients - providing primary care for a disproportionate number of low-income, chronically ill, racially and culturally diverse Oregonians; many of whom experience homelessness, language barriers, mental illness, geographic isolation and lack of health insurance.
- Laboratories for innovation – especially adept at meeting the needs of complex patients and developing creative and culturally attuned approaches to providing comprehensive and integrated care.
- Essential to primary care capacity – The rest of the health care system could not absorb these patients if the safety net disappeared



**BACKGROUND....MIC-VALLEY HEALTH CARE ADVOCATES
February, 2008**

Interested citizens, educators, health care providers, health care activists, persons from faith communities and other residents of the Corvallis-Albany area form the membership of Mid-Valley Health Care Advocates.

Since 1991 MVHCA has been providing educational forums, writing letters to the editor and advocating in various ways to achieve quality, affordable health care for ALL Oregonians. As a local chapter of Health Care For ALL-Oregon, MVHCA assisted in the Ballot Measure 23 campaign in 2002

More recently members of MVHCA have participated in the Archimedes Movement, organized 12 community health care forums, attended meetings and testified at hearings on SB 329 and SB 27 during the 2007 legislative session, and promoted interest in participating in the Oregon Health Fund Board and its committees.

In its educational and advocacy activities MVHCA has collaborated with a variety of community and statewide organizations including, but not limited to Corvallis League of Women Voters, Samaritan Health Services, Interfaith Health Care Network, Physicians for National Health Program, Oregon Health Action Campaign, Oregonians for Health Security and Ecumenical Ministries of Oregon.

Chair: Rich Lague, PT
230 SW Second St.
Corvallis, OR 97333

Treas: Mike Beilstein
1214 NW 12th St.
Corvallis OR 97330

Organizer: Betty Johnson

**MID-VALLEY HEALTH CARE ADVOCATES PRESENTATION
to
OREGON HEALTH FUND BOARD**

February 19, 2008

Presentation by: Mike Huntington MD and former Oregon Senator, Cliff Trow

Mid-Valley Health Care Advocates is well aware that the Oregon Health Fund Board is engaged in a very challenging process to create a comprehensive plan for quality , affordable and sustainable health care available to all Oregonians.

We recognize that we do not have all the answers, but are absolutely committed to explore ALL the options to achieve our mutual goals.

Mid-Valley Health Care Advocates propose the addition of a non-profit, publicly owned and publicly administered health plan to the mix of Accountable Health Plans described in The Healthy Oregon Act, SB329. We are confident that this Oregon Health Insurance Plan (OHIP) will more directly address the roots of our health care crisis.

Based on experience in other states, we believe that SB 329's mandate for all Oregonians to buy private health insurance will produce a *new* gap in health insurance coverage, unless a non-profit, publicly owned and publicly administered health plan is offered as one of the available options. The *new* gap will be, not as now between the uninsured and the insured, but between the *scope* of benefits offered to Oregonians.

As a non-profit, publicly owned and publicly administered health plan OHIP will have minimal administrative costs and no profit requirements, thus providing significant revenue to expand health services beyond the essential and effective health services required by OHFB.

All Oregonians, including Oregon employers, would have the choice to participate in the Oregon Health Insurance Plan or one of the private Accountable Health Plans.

Operations of this non-profit, publicly owned and publicly administered health plan will be transparent and accountable to Oregonians. All health plans must be held accountable but we propose that OHIP will be particularly effective in ensuring public access to important decision-making. Public hearings will be standard operating procedure as benefits , incentives and other major policies are developed; decisions will be a matter of public record, open for Oregonians to review and propose changes.

The Oregon Health Insurance Plan will be sustainable in the long term for our society. With its user-friendly, simple enrollment and administrative procedures, its focus on preventive and primary care, as well as other quality and cost control features, OHIP will be sustainable over the long term.

Justice and fairness dictate that all Oregonians and Oregon businesses have a full range of choices in the market place...including choice of a non-profit, publicly owned and publicly administered health plan among the other Accountable Health Plans available through the Insurance Exchange.

The Oregon Health Insurance Plan is a stellar example of how to achieve Goal # 6 of The Healthy Oregon Act regarding public private partnerships. OHIP will “*integrate public involvement and oversight, consumer choice and competition within the health care market*”.

Mid-Valley Health Care Advocates request that the Oregon Health Fund Board thoughtfully consider the proposal for the Oregon Health Insurance Plan and assign the concept we have described to the appropriate OHFB committee(s) for further research and development, with the assurance of full public participation, including Mid-Valley and other health care advocates.

The proposed Oregon Health Insurance Plan offers another challenge and opportunity for us to blaze a new Oregon Trail to ensure achievement of Goal #3 SB329:

“*high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost*”. Mid-Valley Health Care Advocates would add that the cost must be sustainable for society, as well as for individuals and businesses.

Thank you for considering the Oregon Health Insurance Plan and our request for further research and development.

Oregon Health Fund Board



Eligibility and Enrollment Committee

Affordability Recommendations to the Board

February 13, 2008

[THIS PAGE INTENTIONALLY LEFT BLANK]

Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

Table of Contents

Committee Membership	1
Executive Summary	4
Introduction	8
Background	
Proposed Cost-Sharing Structure Options	
Summary of Committee Comments	
Recommendations	
Recommendation #1: Total Cost-Sharing Limits	14
Recommendation #2: State Premium Assistance	15
Recommendation #3: Cost-Sharing Structure	16
Recommendation #4: State Tax Relief for Premiums	16
Additional Recommendations to Other OHFB Committees:	17
Population Affected by Affordability Recommendations	18
2008 Federal Poverty Guidelines	19

Committee Membership

Ellen Lowe, Chair

Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Jim Russell, Vice-Chair

Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Robert Bach

Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Jane Baumgarten

Retired
Coos Bay

Felisa Hagins

SEIU Local 49
Portland

Dean Kortge

Senior Insurance Specialist
Pacific Benefits Consultants
Eugene

Noelle Lyda

Ed Clark Insurance, Inc.
Salem

C.J. McLeod

Senior Vice President and Chief Marketing Office
The ODS Companies
Portland

Eric Metcalf

Director of Health Services
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians
Coos Bay

Bill Murray

CEO
Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney

Health Policy Advocate
Oregon Health Action Campaign
Corbett/Salem

Susan Rasmussen

Manager, Special Programs
Kaiser Permanente NW
Portland

Carole Romm, RN

Director
Community Partnerships and Strategic Development, Central City Concern
Portland

John Mullin

Oregon Law Center
Portland

Ann Turner, MD

Physician and Co-Medical Director
Virginia Garcia Memorial Health Center
Portland/Cornelius

[THIS PAGE INTENTIONALLY LEFT BLANK]

Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program. In developing these recommendations, the Committee met six times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee’s task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

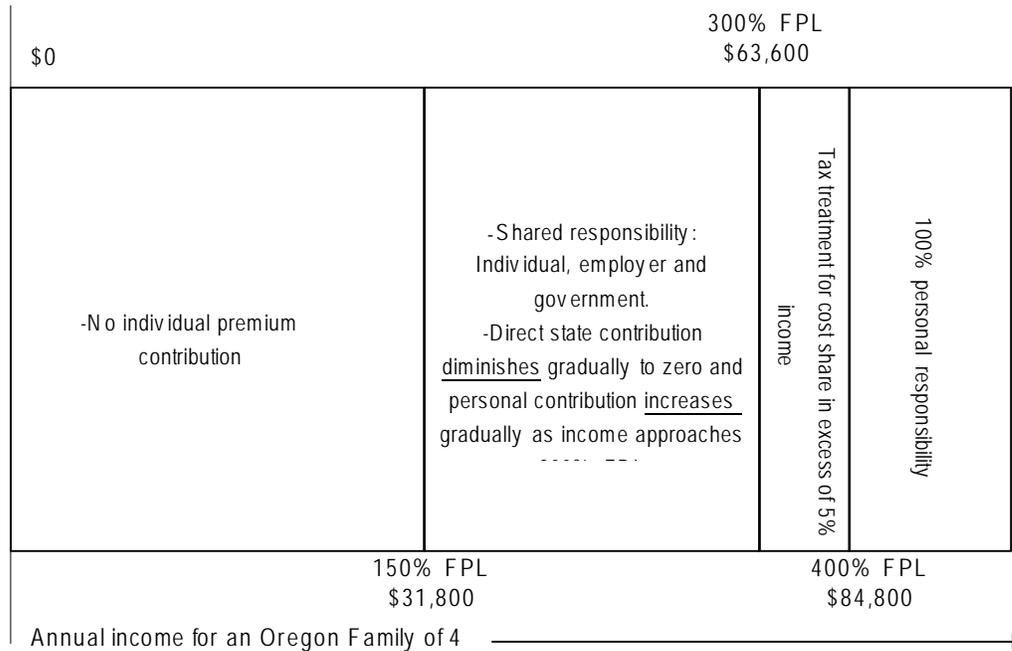
Increasing Annual Household Income 

<p>No Personal Cost Share For Premium Below x% FPL?</p>	<p>Shared State, Individual, and Employer Responsibility Between x% and x% FPL?</p>	<p>100% Personal Responsibility – No State Participation Above x% FPL?</p>
---	---	--

Affordability Recommendations

- ❖ For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- ❖ Structure the personal cost share to emphasize premiums over other types of cost sharing.
 - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
 - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- ❖ Design state premium contribution as a gradual sliding scale to avoid a “notch effect” or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- ❖ Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability framework as recommended by the Eligibility and Enrollment Committee:



Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- ❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- ❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- ❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- ❖ Explore potential tax treatments for individuals between 300% and 400% FPL.
- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

[THIS PAGE INTENTIONALLY LEFT BLANK]

Oregon Health Fund Board – Eligibility and Enrollment Committee Affordability Recommendations

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the six meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	208,000	42%	46,000	40%
150% to below 200%	67,000	13%	29,000	25%
200% to below 250%	60,000	12%	10,000	9%
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	499,000	100%	114,000	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [See www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance."¹
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of

¹ Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at <http://econ-www.mit.edu/files/128>.

Massachusetts Foundation, “Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.”²

- Drs. Matthew Carlson and Bill Wright’s presentation of data from a 3-year Medicaid cohort study, “Impact of Copays on a Medicaid Population.”
www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf

Proposed Cost Sharing Structure Options

- A. The first question addressed by the committee was: At what income should a family reasonably be expected to share responsibility for premium cost?

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

- B. The second question addressed by the committee was: At what income level should premium cost be 100% personal responsibility?

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

² Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, “Setting A Standard Of Affordability For Health Insurance Coverage” *Health Affairs*, July/August 2007; 26(4): w463-w473.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit (\$15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty (\$26,000 annual income for one person), while a few others felt that the state contribution should not phase out until 400% of federal poverty (\$41,600 annual income for one person).

An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility

package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable.....Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option [150% FPL] increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning \$50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, “Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required.” Another member felt that sustainability included maximizing our federal leverage, “Still, in terms of maximizing federal contributions, I ... favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this.”

For the numbers of people potentially impacted by the Committee’s recommendations, see the attached chart, “Population Affected by Affordability Proposal.”

Recommendations

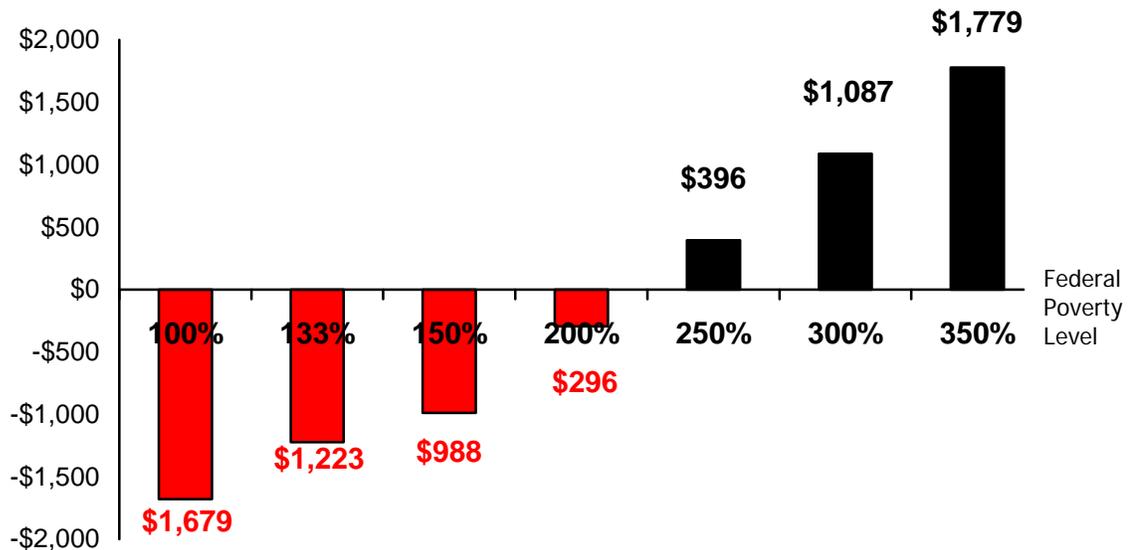
Recommendation #1: For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.

Proposal Overview

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute’s review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee’s recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee’s review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family’s income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



Source: Economic Policy Institute “Basic family budget calculator” Accessed online <12.05.06>
http://www.epi.org/content.cfm/datazone_fambud_budget

As one member noted, “A model that looks only at subsidies for ‘insurance premium’ costs when ... out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums...is unknown, cannot hope to succeed on the basis of ‘equity’ or ‘sustainability’. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring ‘affordability’.” Another member echoed the “administrative simplicity” sentiment by suggesting potentially

simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation #2: Structure individual cost sharing to emphasize premiums over other types of cost sharing.

- **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
- **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee's approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *unaffordable*?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of the federal poverty level (FPL) or \$53,000 annually for the Portland area, 200% of FPL or \$42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL (\$42,000) in the Portland area, 250% FPL (\$35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level (\$15,600 for an individual or \$31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

Recommendation #3: Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them – Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #4: Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- ❖ Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- ❖ Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- ❖ Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

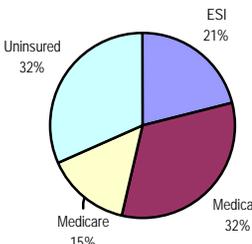
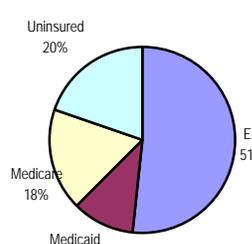
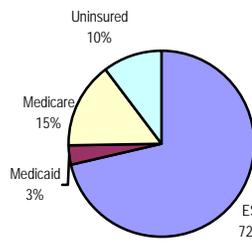
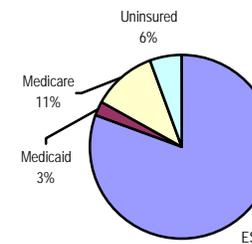
For the Finance Committee

- ❖ Explore potential tax treatments for individuals between 300% and 400% FPL.
- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- ❖ An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	150% to below 300% (Shared Contribution)	300% to below 400% FPL (Tax treatment)	400% and above (100% personal premium contribution)
<p>806,000 Oregonians -550,000 insured (68%) -255,000 uninsured (32%)</p> <p>Insurance source for < 150% FPL:</p> 	<p>1,032,000 Oregonians -828,000 insured (80%) -204,000 uninsured (20%)</p> <p>Insurance source for 150% FPL to below 300% FPL:</p> 	<p>513,000 Oregonians -458,000 insured (89%) -55,000 uninsured (11%)</p> <p>Insurance source for 300% FPL to below 400% FPL:</p> 	<p>1,311,000 Oregonians -1,211,000 insured (93%) -99,000 uninsured (7%)</p> <p>Insurance source for 400% FPL and above:</p> 

Data from CPS 2-year average, Data collected in 2006 and 2007.

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	\$10,400	\$15,600	\$20,800	\$26,000	\$31,200	\$36,400	\$41,600
2	\$14,000	\$21,000	\$28,000	\$35,000	\$42,000	\$49,000	\$56,000
3	\$17,600	\$26,400	\$35,200	\$44,000	\$52,800	\$61,600	\$70,400
4	\$21,200	\$31,800	\$42,400	\$53,000	\$63,600	\$74,200	\$84,800
5	\$24,800	\$37,200	\$49,600	\$62,000	\$74,400	\$86,800	\$99,200
6	\$28,400	\$42,600	\$56,800	\$71,000	\$85,200	\$99,400	\$113,600
Each add'tl person, add	\$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*
- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:

- Oregon Health Fund Program would not be “universal” in that low-income non-qualified Oregon residents excluded;
- This option doesn’t address the “cost-shift” from uncompensated care as well as public health concerns created by exclusion; and,
- The “play or pay” amount from businesses employing non-qualified workers not provided to those workers.

Advantages:

- No specific federal waiver would be needed;
- Option takes ‘hot button’ issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:

- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts ‘hot button’ issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:

- Oregon Health Fund Program would be “universal” in that all Oregon residents included;
- Addresses both the “cost-shift” from uncompensated care as well as public health concerns created by exclusion; and,

**Final Recommendations to the Oregon Health Fund Board (OHFB) and the
Eligibility & Enrollment Committee of the OHFB**

- The “play or pay” amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility “play or pay” payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be “universal” in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both “cost-shift” from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians