Oregon Health Fund Board

Federal Laws Committee

Draft Report to Oregon's Congressional Delegation

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DRAFT TO OREGON HEALTH FUND BOARD

July 21, 2008

Oregon Health Fund Board—Federal Laws Committee
Draft Report to Oregon's Congressional Delegation

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Federal Laws Committee Charter
Approved by OHFB on: December 12, 2007

I. Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

II. Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Healthy Oregon Act including, but not limited to, the following:

1) Medicaid requirements relating to such areas as: eligibility categories, household income limits, Medicaid waivers, Federally Qualified Health Centers (FQHCs), and reimbursement for training of health professionals; and related policy areas including the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP);
2) Medicare requirements including issues related to Medicare Advantage Plans as well as policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate," including:
    - How such Medicare policies and procedures affect costs, quality and access;
    - How an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care;
3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further federal courts decisions;
4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers;
6) Health Insurance Portability and Accountability Act (HIPAA) requirements that may hinder coordination of care; and
7) Any other area of federal policy that inhibits Oregon's ability to move forward with health care reform efforts.

III. Timing

In December 2007 and January 2008, the Committee will solicit written comments from the public and key stakeholders on the impact of federal policy on Oregon's reform efforts and recommendations to remove barriers to these efforts. From January – April 2008, the Committee will hold a series of meetings to include panels of stakeholders to present on and discuss selected areas of federal policy. The results of these meetings will inform the Committee's findings and recommendations.

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The draft report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation.

Although SB 329 requires this report no later than July 31, 2008, the Board will request the Oregon Legislature's approval to change the due date to October 1, 2008. This change will allow the report of this Committee to be presented in a series of public hearings during the summer of 2008 along with the Board's draft comprehensive plan. Public comments gathered at these meetings will be incorporated into the final report. Whether or not the deadline change is approved, the Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

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MEDICAID

INTRODUCTION: Oregon's current Medicaid program is known as the Oregon Health Plan (OHP). OHP includes two programs: OHP Plus, for Oregonians categorically eligible for Medicaid or SCHIP benefits under federal rules and OHP Standard, for Oregonians eligible based on income. OHP Standard is Oregon's expansion population of low income, childless adults, approved under its demonstration waiver with CMS. This program has fewer benefits and higher cost sharing than the OHP Plus program. (See Appendix A for a history of the OHP program.)

The innovation that most sharply and controversially characterizes OHP is its systematic approach to rationalizing health care expenditures. OHP provides a standard health benefit based on ranking the effectiveness and value of medical treatments. The Oregon Health Services Commission creates and maintains the "Prioritized List" of diagnoses paired with evidence-based treatment. This list ranks diagnosis-treatment pairs according to relative importance of treatment, cost, and effectiveness. The Legislature sets the funding level for medical services and these funds are applied to the list, starting at the top and descending until the funds are exhausted. Those treatment services that are "above the funding line" are covered in the OHP benefits package and those that are "below the line" are not covered. The Prioritized List has succeeded in making decisions about the allocation of public resources for health coverage more explicit and accountable. It has also succeeded in making health policy more reflective of the best evidence available on clinical effectiveness.

Oregon's premium assistance program is known as the Family Health Insurance Assistance Program (FHIAP). This program pays from 50 percent to 95 percent of the health insurance premium for low income Oregonians. FHIAP subsidies allow individuals and families to purchase employer sponsored health insurance or individual health plans if insurance is not available through an employer.

Oregon's Current OHP and FHIAP Population

In June 2008, 386,662 people were enrolled in an OHP or SCHIP plan.[1] Of these, 362,383 people were enrolled in OHP Plus (including SCHIP). DHS recently raised the cap on its OHP Standard program, expanding the number of enrollees from fewer than 18,000 beneficiaries in February 2008 to 24,279 in June 2008. As of July 2008 10,181 people were enrolled in FHIAP, reduced from 17,999 in November 2007.[2]

The Federal Laws Committee notes that there is significant flexibility under Oregon's current waivers to expand coverage to approximately 214,000 uninsured Oregonians if state funding were available to secure federal matching funds. Another 145,000 could receive premium assistance under FHIAP were state funding available.

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[1] Total Oregon Medical Assistance Programs Eligibles, June 2008. Department of Human Services, Oregon Health Plan Eligibility Reports, June 2008.

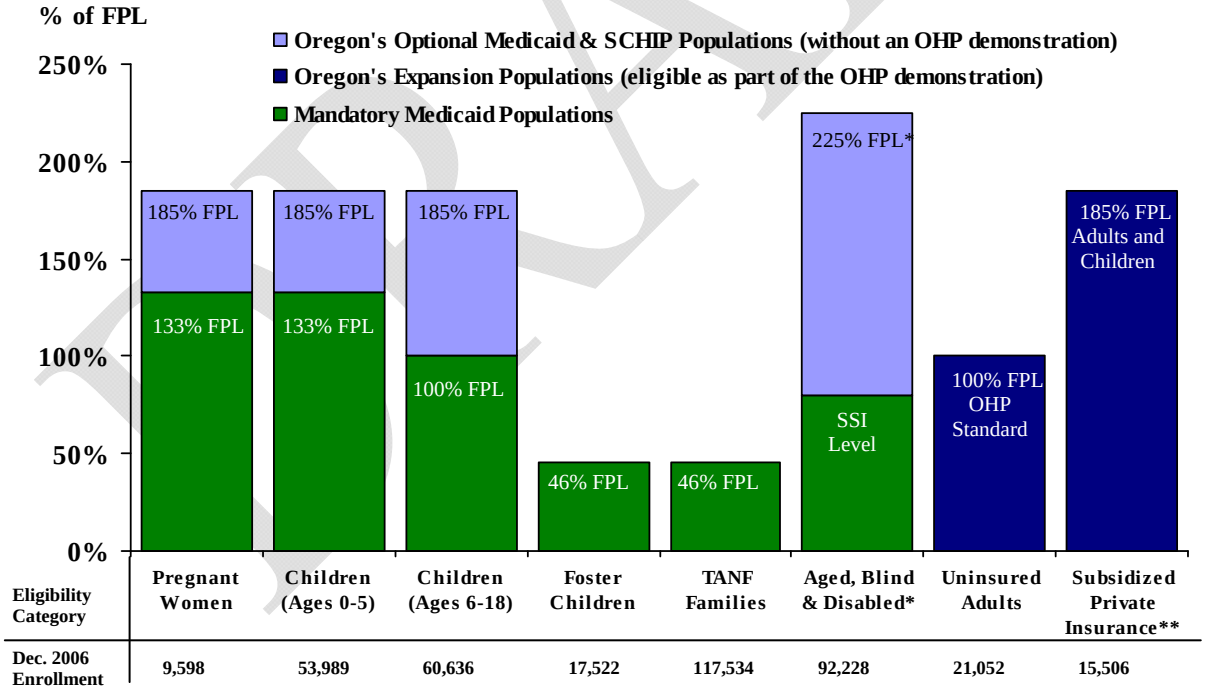
[2] DHS, FHIAP Snapshot of Program Activity, July 14, 2008. As of May 31, 2008, all FHIAP benefits for those 0-85%FPL were be terminated due to a recent CMS ruling that resulted in a General Fund shortfall at the state level. Those enrollees below 85% FPL will be transferred to OHP Standard for a transition period of 6 months, at which point their eligibility to remain in OHP Standard will be reassessed.

RESULTS FROM HEARINGS AND RESEARCH: Expanding eligibility. If the Board's comprehensive plan proposes to expand eligibility beyond the levels in Oregon's current OHP and Premium Assistance waivers, Oregon will need to apply for CMS approval to obtain additional federal matching funds. If CMS denies these requests, these proposed program expansions would be significantly more expensive to implement.

BACKGROUND: There are two areas of Medicaid policy that directly affect state reform efforts: CMS approval of state's Medicaid eligibility criteria (particularly FPL levels) and budget neutrality requirements. In particular, securing federal Medicaid and premium assistance matching funds will be critical to the success of the Board's comprehensive plan.

Oregon's OHP and Premium Assistance Program Waivers: Oregon's waivers provide federal matching funds under FHIAP for premium assistance up to 185% FPL and under OHP for children and pregnant women up to 185% FPL. Most other OHP eligibility categories are below 185% FPL (see chart below). If the Board recommends expanding OHP and/or premium assistance above these levels, an additional waiver or an amendment of the current waivers will be necessary. Of course, if Oregon chooses to finance these expansions out of its own state funds, it is entitled to do so without a waiver.

OHP/FHIAP Eligibility Categories by Percentage of Poverty Level (FPL)



Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)
*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level
**FHIAP subsidizes private health insurance coverage for low income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% FPL must enroll if they have employer sponsored insurance. Parents and childless adults over 100% FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

CMS has indicated reluctance to approve states' waivers above 250% FPL. In August, 2007, CMS issued a rule that significantly restricted states' ability to use SCHIP federal funds to cover children above 250% FPL. According to CMS's rule, a state may use SCHIP funds to cover children above 250% FPL only if the state can demonstrate 90% coverage of those children below 250% FPL, which is an extraordinarily high coverage rate to achieve. In January, 2008, CMS denied Ohio's request to increase Medicaid eligibility to 300% FPL. In doing so, CMS indicated that it would likely use the same criteria for eligibility limits for SCHIP as for Medicaid.

It is unclear how these limits on SCHIP and Medicaid eligibility would affect a CMS decision on expanding premium assistance eligibility. In recent years CMS has generally reacted favorably in granting waivers for premium assistance programs. However, there is not clear precedent or guidance as to whether CMS would approve a waiver that increased eligibility for a premium subsidy program up to 300% FPL.

Budget Neutrality: The second area of Medicaid policy that directly affects state reform efforts is the federal requirement that all waiver programs be budget neutral. This means that CMS may not approve a plan that would result in a higher level of federal spending than would otherwise already occur under the state's Medicaid program. This requires comparing the state's projected "with waiver" costs over the life of the waiver with the state's projected "without waiver" costs. Therefore states may not expand programs without either (a) demonstrating cost savings elsewhere; or (b) cutting other programs. Any expansion of Oregon's current Medicaid programs that the Board proposes must be budget neutral. According to Jim Edge, Oregon's State Medicaid Director, Oregon's Medicaid program is currently operating below its budget neutrality calculation, so Oregon has room to expand its Medicaid program somewhat without violating the budget neutrality mandate. Although not an immediate barrier to reform in Oregon, budget neutrality requirements may impede other states' reform.

MCO Provider Tax Sunset: OHP Standard is currently funded solely by two taxes: two-thirds of the funding is from a tax on Oregon's Fully-Capitated Health Plans (called the Managed Care Organization (MCO) provider tax), and the remainder of funding is from a hospital tax. These taxes will sunset in September, 2009. Replacements for these taxes have not yet been identified.

RECOMMENDATIONS:

1. When Oregon's health reform is enacted, CMS should approve Oregon's request to expand coverage under its OHP and premium assistance waivers. Federal matching funds will be instrumental in the success of Oregon's reform package and will allow Oregon to significantly reduce the number of uninsured in the state. This committee supports the expansion of state funding, understanding that that is a necessary prerequisite for expanding federal funding.

2. *STATE RECOMMENDATION: The Health Fund Board and Oregon legislature need to be aware of and develop contingency plans for the OHP Standard program if there is a timing gap between the MCO provider tax sunset and the implementation of the Oregon's reform package.*

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RESULTS FROM HEARINGS AND RESEARCH: Payment structure flexibility.
Oregon does not have the flexibility within its current Medicaid waiver to change the Medicaid Managed Care Organization and provider payment structure from encounter-based payments to payment for best practices.

BACKGROUND: Medicaid's current structure for payments to providers is similar to that in the commercial marketplace: providers are paid on a fee for service basis. They are not currently reimbursed for managing a population of patients using disease management techniques, telephone consultation, and other approaches. Payments are based on approved specific reimbursable services, and do not specifically reflect morbidity reduction or improved quality of care. If the Board proposes changes in the payment structure to reward services that result in healthier outcomes and emphasize quality primary care, these would not be reimbursed under the OHP waiver.

A state may change its Medicaid payment structure through its Medicaid State Plan or through a waiver. Generally, changes in payment structure are made through the State Plan. The State Plan is the state's contract with CMS that lays out exactly how the state plans to use federal matching funds. It is through the State Plan that state and the federal governments agree upon how the state will manage and administer the Medicaid program. The State Plan also includes the formulas for payment calculations to Medicaid Managed Care Organizations (in Oregon, these are the Fully-Capitated Health Plans). Under Oregon's current payment system, the formulas for MCO payment are based on cost of care and number of patient-provider encounters over the previous three years, along with projected costs and actuarial information looking forward. Should the state seek a different payment system or incentive structure, CMS would have to approve the new system.

Whether a state must seek change through a waiver or a State Plan is largely a subjective CMS decision based on how comprehensive the change in the payment structure will be. If the change in payment structure will result in a sweeping change in how care is delivered, CMS is likely to require that the new payment structure approval be submitted via waiver (or in Oregon's case, an amendment to our current OHP demonstration waiver). Since the waiver process can be long and arduous, requiring the state to submit a waiver would be time-consuming and would delay reform.

RECOMMENDATION:

3. CMS should adopt a framework and an expedited approval process to assist states experimenting with payment reform. CMS should allow states to use the State Plan amendment process whenever possible to allow states to modify payment strategies to reward improved outcomes and efficiency.

4. CMS should engage in a timely manner with states in the review, renewal, and approval of waivers. Lengthy, multi-year waiver approval greatly hinders states' reform efforts.

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RESULTS FROM HEARINGS AND RESEARCH: Federal citizenship documentation requirements. CMS citizenship documentation requirements appear to be preventing eligible Oregonians from enrolling in Medicaid/Oregon Health Plan.

BACKGROUND: Eligibility for Medicaid is restricted to US citizens, nationals of the United States, or qualified aliens.[3] Until 2005, the federal law for verifying citizenship for Medicaid eligibility required "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States."[4] The Deficit Reduction Act (DRA) of 2005 issued new citizen documentation requirements for all Medicaid applicants, including those recertifying eligibility. Applicants must provide specific documentation to become eligible for Medicaid benefits (see table below). In 2006, SSI and Medicare beneficiaries, foster children and children receiving adoption assistance were exempted from the documentation requirement. These requirements became effective Sept. 2006.

Acceptable Stand-Alone Documents	**Acceptable Pairs of Documents: Must have both a Citizen Document and an Identification Document**	
	Citizen Document	**Identification Document**
U.S. Passport	Birth certificate	Current state driver's license or state identity card
Certificate of Naturalization	Report or Certification of Birth Abroad of a U.S. Citizen	School identification card
Certificate of U.S. Citizenship	U.S. Citizen I.D. card	Federal, State or Local government identification card
	Adoption papers	U.S. Military identification card
	Military Record if it shows where you were born	

From CMS brochure: "Providing Documentation of Citizenship for Medicaid"[5]

Medicaid enrollment processes prior to the DRA requirements: Prior to the DRA, Oregon and 46 other states allowed applicants to self-declare US citizenship for Medicaid. Most of these (including Oregon) used "prudent person policies" which required applicants to provide documentation if their statements seemed questionable to eligibility staff.[6] In 2001, CMS encouraged self-declaration policies because these made the application process simpler and quicker, and offered guidance to states on verifying self-declaration statements, either against other sources or via post-eligibility reviews.

Oregon examined its enrollment processes prior to implementing the DRA requirements and found limited cause for concern. A 2002 Secretary of State audit that examined Oregon's enrollment processes found two cases where ineligibles received full coverage. The

[3] The only exception is that nonqualified citizens receive Medicaid reimbursement for emergency care under the Citizen/Alien-Waived Emergent Care (CAWEM).
[4] Social Security Act, Section 1137(d).
[5] http://www.cms.hhs.gov/MedicaidEligibility/downloads/Citizenshipbrochure.pdf
[6] "Self-Declaration of US Citizenship for Medicaid," (OEI-02-03-00190) Office of Inspector General, DHHS, July 2005.

methodology of this audit did not allow them to determine the potential extent of the problem – the took a random sample of 25 out of the 812 cases that had been changed from ineligible to full coverage, and found 2 cases where the fully covered person was ineligible. The audit also found that allowing a self-declaration on the mail-in application increased the risk of providing full OHP coverage to ineligible non-citizens and that the quality control reviews of OHP enrollment did not include verification of citizenship.

According to this state audit and a national-level Inspector General report, improving post-eligibility quality control could address vulnerabilities inherent in self-declaration policies. The Secretary of State's report included a recommendation that DHS "include verification of citizenship status in the quality control reviews of OHP approved cases to determine the significance of this eligibility issue." A 2005 study by the US Department of Health and Human Services Office of Inspector General also examined self-declaration policies for Medicaid coverage. This study recommended that CMS strengthen post-eligibility quality controls in states that allow self-declaration, provide states with a clear list of acceptable citizenship documents, and consider allowing states to refer to citizenship verifications from other Medicaid-related programs.

Impact of the DRA citizenship documentation requirements: Two national studies and a study by Oregon's DHS demonstrate that the new citizenship documentation requirements have led to eligible U.S. citizens losing or being denied Medicaid coverage and that the requirements have not achieved the goal of saving taxpayers money. The GAO found that the DRA documentation requirements have led to increased administrative costs and barriers to access including widespread declines in Medicaid enrollment.[7] Of the 44 states responding, 22 reported declines in Medicaid coverage due to the requirement, (12 states reported no effect and 10 reported that the effect was unknown). Most of these states reported that applicants who appeared to be eligible citizens experienced delays in coverage. Although only a few states were able to quantify the loss of coverage for eligible citizens, one state identified 18,000 individuals were denied or lost coverage in the first seven months of implementation. Seventeen of the 22 states expect the downward trend in enrollment to continue.

The House Committee on Oversight and Government Reform Majority Staff examined this issue as well.[8] Their analysis found that the DRA documentation requirements have been significantly more costly to implement than the savings they have produced. For every $100 spent by federal taxpayers to implement the new requirements in six states, only 14 cents in Medicaid savings can be documented. See the results of staff analysis in six states in the Table below. Although it is possible that the new documentation rules dissuaded undocumented immigrants from applying, the staff found "the lopsided ratio of high administrative costs to minimal savings reported by the states indicates that the documentation requirements are likely to cost federal taxpayers significantly more than they generate in savings."

[7] U.S. Government Accountability Office, "*Medicaid: States Reported Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*" (GAO/07-889), July 2007.

[8] House Committee on Oversight and Government Reform, "Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions," July 24, 2007.

Federal spending and the number of undocumented immigrants found

	Additional federal spending	Number of undocumented immigrants found	Number of Medicaid Enrollees (2004)	Federal savings from undocumented immigrants found
Colorado	$1,500,000	0	398,500	$0
Kansas	$750,000	1	253,600	$1,816
Louisiana	$2,000,795	6	816,700	$8,095
Minnesota	$650,000	0	545,000	$0
Washington	$2,500,000	1	953,100	$1,138
Wisconsin	$900,000	0	688,600	$0
Total	**$8,300,795**	**8**	**3,655,500**	**$11,048**

Source: House Committee on Oversight and Government Reform, "Summary of GAO and Staff Findings: Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions," July 24, 2007.

According to an investigation by DHS,[9] more than 1,000 Oregonians (about 1 percent of applicants) lost or were denied Medicaid benefits in the first 6 months of implementation because they were unable to meet the new requirements. Nearly all were believed to be citizens. 91 percent of households with denied individuals were English speaking and 64 percent were children. Other results from this investigation include:

- The most common reasons for being unable to present appropriate citizenship documentation include: "insufficient time to complete the process; lack of money or transportation to obtain or provide the documentation; and/or misunderstandings regarding which documents were still needed for completing the process, particularly the Proof of Identity for children."
- The DHS investigation found that "in some cases children were forced to go without medical care as minor health problems grew into serious, life-threatening issues; some adults were forced to delay needed surgeries; and families incurred medical bills they could not afford to pay."
- Despite efforts to mitigate the potentially harmful effects of the documentation requirements, DHS "expects the new federal law will continue to disadvantage those citizens with the fewest resources and will cause eligible citizens, especially children, to lose benefits."

RECOMMENDATION (PENDING FINAL COMMITTEE REVIEW):

5. Research has established that there is little benefit to the DRA requirements and possibly significant harm when eligible citizens are unable to qualify for Medicaid benefits. States that can demonstrate quality standards and good enrollment processes should be allowed to revert to pre-DRA requirements.

[9] "Implementation of the US Deficit Reduction Act of 2005 in Oregon and Its Impacts on OHP Clients: An overview of the effects of the new identity and citizenship documentation requirements during the first six months of implementation, Sept 1, 2006 – Feb 28, 2007," Oregon Department of Human Services. All quotes are from this report unless otherwise indicated.

RESULTS FROM HEARINGS AND RESEARCH: Recent CMS Rules. Recent CMS rulings have tended to decrease state flexibility in terms of benefits, eligibility and delivery of health care. Many recent policies have resulted in significant shifting of health care costs to the states. If six recent CMS rules had been implemented, Oregon would have lost or incurred costs up to $921.4 million in federal Medicaid funding between FY2008 and 2013. The moratorium on these rules expires April 2009.

BACKGROUND: In 2007, CMS issued several proposed rules and final rules announcing new policies narrowing the types of activities and expenditures for which states could claim Medicaid reimbursement. The proposals would have limited the federal financial participation (FFP) for (1) rates paid to government-operated providers and expenditures; (2) state payments for graduate medical education; (3) rehabilitative services; (4) school-based transportation for severely disabled children; (5) the definitions of "case management services" and "targeted case management services; and (6) healthcare-related taxes counted toward state expenditures eligible for federal matching funds. Fortunately, H.R. 2642, the Supplemental Appropriations Act of 2008, became law in June. This legislation extends the moratoria imposed on CMS Medicaid rulemaking enacted in previous legislation until April 1, 2009.

The following table lists the impact CMS's regulations would have had on Oregon's Medicaid system if Congress had failed to enact the moratoria.

Regulation	Impacts	Oregon Medicaid Reduction/Cost
School-based Services CMS 2287-P (Dec. 28, 2007)	• This rule results in the loss of 50% federal match for School Medicaid Administrative Claiming (MAC) over the past 3 years averaged $20 million per year, $10 million from federal funds. • Elimination for federal reimbursement for Medically Necessary Transportation provided to children with disabilities pursuant to an IEP or IFSP under IDEIA over the next 5 years = $1.4 million.	$10.3 million FY 2009 $54.8 million FY 2009-2013
Rehabilitation Services CMS 2261-P (Aug. 13, 2007)	• The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. • If there are no methods for billing these services, they cannot be offered by the State Medicaid Program. This would have a detrimental effect on clients as they will not receive effective services appropriate to their needs in the least restrictive environment possible. • Some clients may be diverted to other services such as outpatient services while others will be diverted to services such as acute hospital. This change would likely result in an increase in expenditures for hospitalization services.	$72.9 million FY 2009 $378.6 million FY 2009-2013
Targeted Case Management CMS 2237-IFC (Dec. 4, 2007) *	• Child serving agencies, including Child Welfare and the Oregon Youth Authority, will not be able to claim for case management services provided to Medicaid-eligible youth. • Limiting clients to a single Medicaid case manager will reduce the effectiveness of client referrals by requiring case managers to support clients outside their field of expertise. • Other activities that have been historically viewed as administrative and claimed as such will no longer be reimbursed, having adverse impacts on rural communities' support structures which in turn could reduce client access.	$52 million FY 2009 $288-316 million 2009-2013

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Regulation	Impacts	Oregon Medicaid Reduction/Cost
Government Provider Cost-Limit s CMS 2258-FC (May 29, 2007)	• This provision would require that statutory and regulatory criteria be considered when Oregon makes the initial determination about the governmental status of health care providers. • A further provision requires that revenue cannot exceed the costs of providing the Medicaid service and providers must submit annual cost reports to be reviewed by DHS. • More time will be required in monitoring and documentation, which will in turn reduce the amount of face-to-face service time by providers to Medicaid clients. • The administrative burden may cause smaller, typically rural providers to withdraw from providing Medicaid services.	$6.2 million FY 2009 $33 million FY 2008-2013, Cost to the state in administrative dollars.
Graduate Medical Education CMS 2279-P (May 23, 2007)	• This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities. • Teaching hospitals are where the nation's health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. • Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that depends on reliable, long-term financial support. • Teaching hospitals are an integral part of the traditional care for local communities.	$ 21.1 million FY 2009 $110.7 million FY 2009-2013
Provider Tax CMS 2275-P (Mar. 23, 2007)* *	• Oregon has a Medicaid Managed Care Organization (MCO) provider tax as well as a Nursing Facility tax. The MCO provider tax revenue is the state funding source for the Oregon Health Plan expansion population (OHP Standard). Approximately two-thirds of the expansion population (16,000 clients) is funded by Medicaid MCO provider tax revenue. • For the tax rate change from 5.8% to 5.5% on Jan 1, 2008 to Sept 30, 2009 the loss of state funds will be $10.7 million. With federal matching funds, that money could have covered an average additional 1,700 people per month. • The nursing facility Quality Assurance Assessment fee (also called the nursing facility provider tax) is used to partially pay the costs of Medicaid nursing facility care for Medicaid residents. • If the tax is eliminated, the state will have two options: (1) replace tax revenue with General Fund, or (2) substantially decrease nursing facility Medicaid rates from their current level.	$8.5 million FY 2008 $28.3 million FY 2008 and 2013

Source: Based on Office of Federal Financial Policy, Oregon DHS. Estimated Oregon reductions from all regulations, based on Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008.

*The fiscal range presented assumes that 20%-50% of the clients served are complex enough to warrant multiple case managers.

** Managed Care Provider tax assumes the sun setting of the program in Sept. 2009 the Long Term Care Provider Tax does not sunset until July 1, 2014. The percentage reverts back to 6% in 2011.

RECOMMENDATION:

6. Oregon's Congressional delegation should seek to permanently eliminate the proposed regulations enumerated above that would significantly reduce federal payments to Oregon, so that they are not reinstated after the April 1, 2009 moratorium deadline.

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MEDICARE

INTRODUCTION:
Medicare is a federal program that covers over 571,000 people in Oregon.[10] Of this total, about 86% are aged eligibles (65 or older with ten years of Medicare-eligible employment), and 14% are disabled (as determined by the Social Security Administration). An estimated 79,000 Oregonians are dual Medicare/Medicaid eligible.[11] The total Oregon Medicare enrollment has increased 11.5% from 1996 to 2005.[12]

In Oregon, the population over 65 years of age is projected to increase more rapidly in the next twenty years than it did in the last twenty years. Moreover, the projected growth in this population is expected to be larger in Oregon than it will be on average nationwide – the number of those over 65 is expected to increase 67% by 2020 in Oregon.[13]

Medicare is made up of four component parts:

- Part A includes hospitalization, limited skilled nursing, limited home health, and hospice care. Part A does not include long-term care. The individual is responsible for any co-payments or deductibles.
- Part B is medical insurance and includes physician services and outpatient visits, lab and x-ray, ambulance and some preventive care. Part B requires beneficiaries to pay an out-of-pocket coinsurance and a premium for Part B coverage.
- Part C, formerly known as "Medicare + Choice," is now known as "Medicare Advantage". If an individual is entitled to Medicare Part A and enrolled in Part B, he or she can elect to switch to any of the Medicare Advantage plans offered in their area. These privately run plans are regulated by CMS and are either managed care (HMO or PPO) or fee-for-service.
- Part D, the new prescription drug benefit, implemented in January 2006.

Medicare reimbursement: Provider reimbursement rates under Medicare vary widely by geographic area. CMS calculates physician rates using the "Resource Based Relative Value System (RBRVS)" physician payment schedule. This rate schedule includes data to determine Geographic Practice Cost Indices (GPCIs) that adjust payment rates to account for geographical differences in the costs of furnishing physician services.

There are three GPCIs included in the RBRVS: physician work, practice expense, and professional liability insurance expense. The physician work GPCI is based on earnings of professionals (such as lawyers, engineers, etc.) reported in the decennial census. The practice expense GPCI accounts for geographic differences in non-physician overhead such as staff wages, office space costs, equipment and supplies. The liability insurance GPCI is based on data collected from the largest malpractice insurers in each state. GPCIs are updated every three years.

[10] Centers for Medicare and Medicaid Services (CMS), Office of External Affairs, released 1/31/08.
[11] Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS), prepared for the Kaiser Commission on Medicaid and the Uninsured.
[12] U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2005.
[13] U.S. Department of Commerce, U.S. Census Bureau, Population Division; Center for Public Health Research, CDC WONDER Online Database, March 2003.

GPCIs are constructed so that they have a national average of 1.0. Geographic areas that have costs above the national average have index values above 1.0 and those with below-average costs have index values below 1.0. All three GPCIs are formulaically combined to come up with the Geographic Adjustment Factor (GAF). See table below for Oregon's GPCIs and GAFs.

Oregon's Geographic Practice Cost Indices and Geographic Adjustment Factors, 2008

	Physician Work GPCI	Practice Expense GPCI	Professional Liability Insurance Expense GPCI	Geographic Adjustment Factor (GAF)*
Portland	1.002	1.037	0.453	0.996
Rest of Oregon	1.000	0.926	0.453	0.947

Source: 2008 (1/1 - 6/30) GPCIs and GAF by MEDICARE PAYMENT LOCALITY, presented by Iowa Medical Society
* Calculation for the GAF: (0.52466*work GPCI) + (0.43669*PE GPCI) + (0.03865*MP GPCI)

A calculation known as the Conversion Factor transforms the GAF into a dollar amount under the physician payment schedule. The Conversion Factor formula includes a "Sustainable Growth Rate" variable, which reflects, in part, the performance of the national economy. In July 2008, Congress took action to prevent changes to the Conversion Factor for 2006-2013 that would have reduced physician payments by 10.6 percent. This bill suspends payment reductions for 18 months.

Medicare Advantage Program: Under the Medicare Advantage program, beneficiaries may receive Medicare benefits by enrolling in participating private plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), or private fee-for-service plans (PFFS). PFFS plans differ from Medicare HMOs and PPOs in that they are not required to establish provider networks or to adopt utilization management strategies, and do not coordinate care like most other Medicare Advantage plans. PFFS plans account for a small share of total MA enrollment in the U.S. (19%), but these plans are growing much faster than HMO and PPO plans in recent years. Between November 2006 and November 2007, enrollment in PFFS plans more than doubled, while HMO and PPO plan enrollment increased about 8 percent to 7.2 million beneficiaries. In 2007, there were 1.7 million enrollees in PFFS plans, an increase of more than 800% since December 2005.[14]

The Medicare Modernization Act of 2003 (MMA) created new Medicare Advantage plans known as Special Needs Plans (SNPs) for specific vulnerable populations. "Special needs individuals" were identified by Congress as: 1) institutionalized beneficiaries; 2) dually eligible; and/or 3) beneficiaries with severe or disabling chronic conditions.

Medicare Advantage plans must cover the same services as Part A and Part B of traditional Medicare. Cost-sharing requirements may differ from traditional Medicare as long as they are at least actuarially equivalent: the average projected cost-sharing liability per person must be the same or smaller. Beneficiaries may receive Part D benefits through an MA plan. Finally, beneficiaries who enroll in MA plans also may receive additional benefits, such as reduced cost-

[14] MedPac Report to Congress, March 2008.

sharing, special care coordination and disease management or other products and services not covered by traditional Medicare.

H.R. 6331, the "Medicare Improvements for Patients and Providers Act:" As mentioned above, in July 2008, Congress took action to suspend a severe reduction in payment physicians. To offset this, two provisions of this Act also enacted funding reductions to the Medicare Advantage program.

- The first of these eliminates the remainder of the "stabilization fund" for Medicare Advantage PPOs. This $1.79 billion fund was established to encourage regional PPOs to contract with Medicare by allowing CMS to pay entry and retention bonuses to PPOs that enter previously unserved regions or continue to serve certain regions. Spending from this fund was set to begin in 2012.
- The second provision phases out duplicate payments for indirect medical education (IME) to Medicare Advantage plans. Although the IME payments to plans are related to medical education offered in hospitals, these plans are not required to pass along IME payments they receive to the hospitals in their networks. Hospitals receive IME payments directly, so the Medicare Advantage IME payments were duplicative.

RESULTS FROM HEARINGS AND RESEARCH: Low provider reimbursement rates. The low rate of Medicare FFS reimbursement received by Oregon providers adversely affects several key aspects of Oregon's health care system, and could undermine the reform efforts of the Health Fund Board. Most importantly, low provider reimbursement has severely limited access to providers for Medicare beneficiaries. Further, Medicare's payment system is focused on encounter-based payments, restricting Oregon's flexibility to reform its health care delivery system.

BACKGROUND: As a result of its relative low cost-of-living, its historically efficient health care system, and low utilization rate, Oregon's Medicare reimbursement rates are among the lowest in the nation. In 2006, Medicare spent an average of $6,451 per Medicare enrollee in Oregon compared to the national average of $7,944. Florida's average cost per beneficiary is $9,462 - over $3,000 more per enrollee, per year, on average, than Oregon's.

Low rates severely limit access to physicians: According to the 2004 Physician Workforce Survey, 11.8% of Oregon's primary care physicians did not accept new Medicare patients.[15] By 2006, the percentage had doubled to 23.7% refusing new Medicare patients. Low reimbursement rates were found to be the most significant barrier to physician participation in Medicare and Medicaid.[16] This Committee heard testimony from Medicare beneficiaries and advocates that lack of access to physicians is a major concern in Oregon's Medicare population. Some seniors have found that their physicians will no longer treat them once they turn 65 and become Medicare beneficiaries. Several beneficiaries mentioned enrolling in a Medicare Advantage plan as the only way they were able to find a physician to treat them.

[15] 2004 Oregon Physician Workforce Survey.
[16] 2006 Oregon Physician Workforce Survey.

Medicare payment structure: Similar to the Medicaid payment structure described elsewhere in this report, the traditional Medicare fee-for-service payment system does not reward efficient or coordinated care.[17] There is little flexibility within the traditional Medicare structure to reward providers who improve outcomes, decrease the number of necessary patient contacts, and increase quality of care. CMS is currently working on implementing some quality-based purchasing, or pay-for-performance initiatives. However, the scope of these efforts is fairly limited and provides the state of Oregon little room to implement widespread payment reform to better align incentives with overall goals.

RECOMMENDATIONS:

7. Congress should reform the process for setting Medicare rates to more equitably align reimbursement across the country. In particular, CMS should limit payment updates in high-cost areas as proposed by the Commonwealth Fund.[18] Medicare updates to both hospital payment rates and physician fees are applied nationally, even though Medicare spending per beneficiary varies considerably by locality. The Commonwealth Fund report indicates: "The same update is applied in Miami, Florida – where Medicare spending per beneficiary was $11,352 in 2003 – and Salem, Oregon – where Medicare spending per beneficiary was $4,273 in the same year."

   This Committee supports the Commonwealth Fund proposal to adjust payment updates in each area to reflect the level of total Medicare Part A and Part B spending per beneficiary in that area, relative to the national average. Area-level adjustments would be applied to basic national updates based on projected increases in the Medicare Hospital Market Basket Index and the Medicare Economic Index. Areas above 75th percentile of spending per beneficiary would receive no update – so that projected increases in Medicare spending would not be reflected in the hospital and physician rates for these areas. Areas at or below the 50th percentile of spending per beneficiary would receive the full update. Areas between the 50th and 75th percentile would receive a portion of the update, on a sliding scale. The effect of this policy would be that low-cost, high efficiency areas would see rates increase over time while rates in high cost areas stayed level.

8. *STATE RECOMMENDATION: Oregon's congressional delegation and interested stakeholders should build support for national Medicare rate reform by joining with other states suffering under low Medicare reimbursement rates. In 2007, US Representatives Hooley and Blumenauer supported the "Children's Health and Medicare Protection Act of 2007 (CHAMP Act) bill" which included payments for efficient physicians. That bonus would increase fee-for-service payments for physicians by 5 percent increase in every county in the bottom 5 percent for fee-for-service costs. In Oregon, that includes the following counties: Baker, Benton, Clackamas, Columbia, Deschutes, Hood River, Klamath, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, and Washington. The House passed the bill, but the Senate did not.*

[17] "Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending," Commonwealth Fund, Dec. 2007.

[18] See "Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending," Commonwealth Fund, Dec. 2007, pg. 58-61.

9. CMS should pursue Medicare payment reform that emphasizes evidence based care, integrated health homes and an array of services that support these models.

RESULTS FROM HEARINGS AND RESEARCH: Medicare Advantage. Medicare Advantage HMO and PPO plans offer an opportunity to address access problems while providing coordinated care to beneficiaries, controlling costs, and increasing reimbursement to providers. However, these plans are the subject of much debate in Congress relative to reimbursement models and concerns about inappropriate marketing behavior by some Private Fee-For-Service plans.

BACKGROUND: Oregon's use of Medicare Advantage plans is somewhat unique. Nearly 39% of all Oregon Medicare beneficiaries are enrolled in a Medicare Advantage plan; which is the highest MA plan penetration in the U.S. Nationwide, the penetration is about 19%.[19] Oregon's total MA enrollment is nearly 210,000 (see Table below).

Oregon's Medicare Advantage Enrollment, January 2008[20]

	Medicare Advantage Plan Type				**Total**
	HMO	PPO	Misc. Plans*	PFFS	
Enrollees	125,589	59,348	4,988	19,340	**209,265**
Proportion	60%	28.4%	9.2%	2.4%	**100%**

*Includes cost plans, PACE, and Employer/Union only direct contracts PFFS.

Oregon's Special Needs Plans: Congress created a special type of Medicare Advantage plan to target services to special needs groups: dual eligibles (eligible for both Medicare and Medicaid), beneficiaries in institutions, and beneficiaries with severe or disabling chronic conditions. Special Needs plans (SNPs) function like and are paid like other Medicare Advantage plans, except they must offer Part D drug benefits, and they can limit their enrollment to beneficiaries in their special needs group. This ability to limit enrollment to special needs allows these plans to offer improved care coordination and targeted benefits which may lead to cost savings to the Medicare program and can provide significant improvements for beneficiaries' treatment and quality of life.

In 2007, Oregon had about 17,500 beneficiaries in a handful of Special Needs Plans, nearly all of which are dual-eligible SNPs.[21] This Committee heard testimony from two Oregon SNPs about the benefit to dual-eligibles of targeted services. Beneficiaries in these plans receive assistance managing their conditions as well as managing their Medicaid and Medicare benefits.

[19] Mathematica Policy Research, Inc. analysis of CMS MA enrollment by State County Contract file, February 2008.

[20] CMS Data, January 2008. Notes: The privacy laws of HIPAA have been interpreted to prohibit publishing enrollment data with values of 10 or less. Data rows with enrollment values of 10 or less have been removed from this file. Pilot contracts are excluded from this file. SOURCE: www.cms.hhs.gov/MCRAdvPartDEnrolData/

[21] CMS Health Plan Management System December 2007 data. Does not include plans with enrollment of fewer than 11 beneficiaries.

Physicians treating these beneficiaries have simplified administrative processes for billing and authorizations.

There are some concerns at the national level about SNPs, particularly SNPs other than dual-eligible SNPs. First, CMS is no longer accepting applications for new SNP plans and will not accept expansion of existing SNP plans starting Jan, 2009. Creating a SNP is an attractive strategy for Medicare Advantage plans that can "carve out" high cost beneficiaries from their regular MA plan and lower their bid. Applications for these plans greatly increased beyond CMS original expectations. Another concern is that SNPs have too little federal oversight to ensure their value.[22]

Medicare Advantage reimbursement: bids, benchmarks, and rebates[23]: Medicare pays Medicare Advantage plans a capitated rate to provide Part A and B benefits to enrollees. Except for PPOs, all types of Medicare Advantage plans are paid as "local plans," and are paid based on their enrollees' counties of residence. PPOs can be either local plans or "regional plans," which serve one or more of the 26 regions designated by CMS. In 2006, Medicare began to pay plans under a bidding process.

- Bidding: Plans bid on the cost to provide Part A and Part B services to the average beneficiary. Bids include administrative costs and profit. CMS bases the payment to a Medicare Advantage plan on the relationship between its bid and the local or regional benchmark.
- Benchmarks: local plans' bids are compared to county level benchmarks established by CMS. Benchmarks take the prior year's county payment rate to Medicare Advantage plans and increase it by the projected national growth rate in per capita Medicare spending. These local payment rates are at least as high as the county's rate under traditional Medicare. Regional PPOs' benchmarks are determined separately using a formula that incorporates the plan bids.
- Plan Payments: If a plan's bid is higher than the benchmark, plans receive a base rate equal to the benchmark rate and enrollees pay the difference in the form of a monthly premium. If the bid is lower than the benchmark, plans receive base rate equal to the bid rate. As of 2007, all plan payments are adjusted based on their enrollees' risk profiles. This means that payment for a particular enrollee is the base rate multiplied by the enrollee's risk measure.
- Rebates: Plans bidding below the benchmark also receive a rebate payment of 75% of the difference between their bid and the case-mix adjusted benchmark. Rebates must be returned to enrollees in the form of supplemental benefits or lower premiums.

Oregon's low Medicare reimbursement rates affect the rates that Medicare Advantage plans can offer, since benchmarks are linked to the local Medicare rate. The average monthly payment rate

[22] MedPac: "Update on the Medicare Advantage Program," from "Report to Congress: Medicare Payment Policy," March 2008.
[23] MedPac, "Payment Basics: Medicare Advantage Program Payment System," October 2007.

for MA plans in Oregon is about $761, compared with $842 in the U.S. as a whole.[24] On average, Oregon's MA plans receive the second-lowest rebate in the country (only Washington State's average rebate is lower). This means that even though the average benchmarks in Oregon are higher than Oregon's traditional Medicare rates (at 1.33 times the Medicare rate), Oregon's MA plans are unable to bid significantly below the benchmark to take advantage of the rebate that would be available to them if they were able to bid lower. Oregon's MA plans are unable to provide services for less cost, even in the face of a rebate incentive to do so. This is another indication that Oregon's traditional FFS reimbursement rates do not accurately reflect the cost of care in the state and are inadequate to cover necessary care.

Benefits of Oregon's HMO/PPO Medicare Advantage plans: As discussed above, Medicare patients are bearing the brunt to Oregon's low reimbursement rates by being unable to find physicians willing to provide necessary care. MA beneficiaries in HMO/PPO plans, in contrast, have access to the managed care network of primary care physicians and other providers contracted for by their plan. According to testimony from 4 plans, physicians get paid better under Medicare Advantage and have not been rejecting beneficiaries under these plans. There are other benefits to enrolling in an HMO/PPO-type plan. The managed-care structure of these plans means that beneficiaries are more likely to have inpatient management, to avoid preventable admissions, behavior management through benefit design, reduced physician variation, and more pharmacy management.[25]

PFFS plans tend to be more prevalent in the most rural areas of Oregon. Residents in counties such as Wallowa, Malheur, Baker, and Union have little access, if any, to other HMO, or PPO-type MA plans. In Oregon's Second Congressional District, representing all of Eastern Oregon, PFFS plans make up 29 percent of Medicare Advantage enrollment compared to a statewide average of 9.5 percent.[26]

Across the U.S., many plans have expanded services to rural and other areas with benchmarks that are high relative to Medicare FFS spending because these areas were given increases in payment rates under earlier law. MedPAC analysis based on July 2006 enrollment data shows that Medicare payments to private health plans on behalf of enrollees average 112% of FFS costs for the counties where MA enrollees reside. PFFS plans – prevalent in rural areas where the benchmark rate is significantly higher than Medicare FFS costs—are paid 119% of FFS costs before adjusting for enrollee risk.

Some members of Congress and the Executive Director of MedPAC have expressed some reservations about PFFS plans. As stated above, PFFS plans are paid 119% of traditional Medicare FFS costs, which alone is somewhat worrisome. However, in addition to this, PFFS plans are prohibited by law from linking provider payments to efficiency and they are not held to the same quality standards and regulations that other MA plans are. In contrast to HMO and PPO plans, PFFS plans are not required to: (1) build networks of providers; (2) report quality

[24] *Id.*
[25] Testimony of Dr. Kevin Keck, Providence Health Plan, Federal Laws Committee Meeting, March 13, 2008.
[26] CMS Data, January 2008, www.cms.hhs.gov/MCRAdvPartDEnrolData/ .

measures; (3) offer Part D coverage; (4) limit enrollment to targeted beneficiaries; or (5) offer individual MA plan if offering employer group plan.

Concerns about the rapid growth of MA plans and complaints about misleading marketing strategies has prompted Congress to consider bills that grant more oversight to states in regulating MA marketing practices. Currently, CMS alone has the authority to oversee marketing of MA plans and they have been slow to adequately respond. However, Congress has yet to enact a bill conferring more power on state insurance commissioners, or anyone else at the state level, to oversee MA plan marketing or other abuses.

RECOMMENDATIONS:

10. Medicare Advantage HMO and PPO plans play an important role in providing affordable health coverage to Oregon's Medicare beneficiaries. Congress should preserve this option for Oregon and permit the expansion of Special Needs Plans.

11. Congress and CMS should consider significant reforms to PFFS plans, including more rigorous federal oversight.

12. *STATE RECOMMENDATION: Oregon should expand Medicare Advantage HMO/PPO plan coverage through service area expansions or the creation of new Medicare Advantage plans. To increase access and improve provider reimbursement in areas of Oregon not currently served by Medicare Advantage plans, existing Medicare Advantage HMO and PPO plans in Oregon should consider extending service options to underserved areas in the state. Alternately, local provider organizations in these areas should consider becoming Medicare Advantage HMO or PPO plans or inviting existing plans to expand into their area.*

13. Congress should delegate authority to State Insurance Commissioners to oversee the marketing activities of Medicare Advantage plans in their state, similar to the federal-state partnership that currently exists in regulating Medicare Supplement plans. Commissioners have authority to regulate unscrupulous practices by individual agents selling Medicare Advantage plans, but no authority to address plan practices such as marketing plans and agent compensation packages.

14. *STATE RECOMMENDATION: The Oregon legislature should pass a joint resolution requesting Congressional action to correct reimbursement rate inequities and to preserve Medicare Advantage HMO and PPO plans. The Oregon Health Fund Board's comprehensive plan to the Oregon Legislature should include this recommendation.*

DRAFT

ERISA

RESULTS FROM HEARINGS AND RESEARCH: ERISA law is unclear in relation to some elements of states' efforts to reform health care, especially related to setting minimum standards for acceptable health insurance coverage offered by self-insured employer plans and health reform funding options such as "pay-or-play" employer payroll taxes and taxes on insurance plans. This lack of clarity leaves innovative states at risk for ERISA-based lawsuits and may prevent some states from implementing innovative health care reform. Further, ERISA hinders states' ability to collect even basic data on self-insured plans, including the number of lives covered under such plans, impeding state public policy efforts.

BACKGROUND:
The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private sector retirement, health, and other welfare benefit plans. Congress' intent in passing this law was to enable employers that operate in more than one state to offer uniform benefits to all of their employees. However, at the state level, ERISA creates an obstacle to health reform efforts through a broad provision that preempts state laws that "relate to" private sector employer-sponsored pension and fringe benefit programs, including health insurance.[27]

The U.S. Supreme Court has held that a state law "relates to" self-insured employer plans if it refers to such plans; substantially affects their benefits, administration, or structure; or imposes significant costs on such plans. Various courts have held that, according to ERISA, states cannot require employers to offer health coverage; dictate the terms of an ERISA plan's coverage, employer's premium share, etc.; or impose taxes on self-insured employer plans. (ERISA exempts from preemption the authority for states to regulate insurance, which includes taxing and collecting information from health insurers and setting standards for products purchased by insured employer health plans). These rulings limit states' ability to set minimum standards for insurance coverage, design unchallengeable "pay-or-play" employer payroll taxes, or tax self-insured plans. Although there have been no court rulings specifically involving collecting data from self-insured plans, such data collection arguably duplicates Department of Labor rules and affects plan administration, and could thus be challenged under ERISA. No states have yet attempted to impose data collection on self-insured plans.

Travelers Insurance Decision: The Supreme Court's interpretation of the ERISA preemption clause was broadened somewhat by the 1995 *Travelers Insurance* decision. In this case, the Supreme Court upheld a New York law that set hospital rates in that state even though doing so had the potential to increase costs for ERISA plans by providing lower rates for Blue Cross than commercial insurance. The reasoning behind this decision was that hospital rate-setting is traditionally an area of state authority and thus not presumed eligible for a congressional override. Also, the Court held that, even though commercial insurance was more expensive than Blue Cross, the New York law did not hinder an employer's ability to choose which insurance

[27] ERISA background information comes primarily from the presentation to the Federal Laws Committee and other documents authored by Patricia Butler, JD, DrPH, health policy analyst/consultant. See "ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's 'Fair Share Act'," Patricia A. Butler, JD, DrPH, State Coverage Initiatives report, Feb. 2007.

plan to purchase. Despite this broader interpretation of the law, states and localities continue to struggle with designing health reform plans that will not provoke a legal challenge under ERISA.

Other States' and Localities' Experiences: In 2007, federal courts found "pay-or-play" payroll tax initiatives in one state and one county to be in violation of ERISA. In Maryland, the disputed law required employers with more than 10,000 employees to either spend 8% of their payroll on health services for their employees or pay the difference between that amount and what they actually spent to the state to help fund the state's Medicaid program. The Court of Appeals held that the purpose of the law was to force Wal-Mart, the state's only employer that would have been affected by the law, to expand its ERISA health insurance plan, which would interfere with uniform national administration of the employer's health benefits plan.

In Suffolk County, New York, a similar "pay-or-play" arrangement was found to be in violation of the ERISA preemption clause. In this case, the county required large grocery retailers to spend the same amount per employee on health care as the county would have to spend to treat an uninsured worker. Any employer spending less than that amount would be required to pay the county the difference. While the stated objective of the law was to protect small businesses that were currently providing coverage to the employees from unfair competition, the appeals court applied the same reasoning as was used in the Maryland case to hold that ERISA preempts the Suffolk County ordinance.

In an as-of-yet unresolved case, a local "pay-or-play" ordinance in the city of San Francisco has been challenged under ERISA. The ordinance requires firms with workers employed in the city to spend a certain amount per-worker, per-hour on health benefits or pay the equivalent amount to help fund the city's Health Care Access Program. A federal district court ruled that the ordinance violated ERISA's preemption clause, but the Court of Appeals has granted a stay of the lower court's order. The Court of Appeals characterized the city ordinance as requiring employer payment, not employee benefits, holding that neither choice – the employers' choice to provide health care nor their choice pay the city – is favored by the ordinance.

In general, under the reasoning of the Travelers case, a "pay-or-play" initiative is most likely to withstand an ERISA challenge if it is a broad-based, tax-financed program; the state is neutral regarding whether employers offer coverage or pay tax; and the state does not set standards to qualify for tax credits or otherwise refer to ERISA plans.

NAIC's Recommended Changes to Federal Law:[28] Responding to states' concerns regarding reforming their health care systems while complying with federal law, the National Association of Insurance Commissioners (NAIC) recently conducted a survey of states' Departments of Insurance, asking if they had "considered the preemptive effect of ERISA, HIPAA, or any other federal law on innovations related to making health care insurance or alternative health care financing mechanisms more affordable, particularly with respect to small group markets?". Two-thirds of the states that responded had encountered situations where federal law preempted, or threatened to preempt, health reform proposals. To address these issues, NAIC has developed

[28] "NAIC Recommendations for Federal Action," Federal Relief Subgroup, State Innovations (B) Working Group, National Association of Insurance Commissioners, May 2007.

a set of recommendations that would maximize states' flexibility in reforming their health care systems while minimizing the impact on sponsors of ERISA plans.

These recommendations are: 1) Amend ERISA to clarify that states may require self-insured plans to submit data regarding coverage, premiums, cost-sharing arrangements, and utilization; 2) Amend ERISA to clarify that "pay-or-play" assessments that meet specified criteria are not preempted by federal law; 3) Grant the Secretary of Labor the authority to grant waivers from ERISA to states that implement comprehensive health reform proposals; and 4) Create a federal grant program to provide grants to states pursuing new and innovative reform ideas.

Concerns Regarding the Oregon Health Fund Board: In its recommendations to the Health Fund Board, the Finance Committee is proposing a "pay-or-play" employer payroll tax as one of the revenue sources for the Board's comprehensive health care reform plan. While the Finance Committee believes it has designed a payroll tax that could withstand a challenge under ERISA, the possibility of such a challenge does still exist. Clarity from the federal government with regard to this type of payroll tax initiative would allow the state to design a policy without fear of encountering a costly lawsuit. (See the first recommendation below.)

RECOMMENDATIONS:

15. Congress should create "safe harbor" policies for state health care reform elements (such as "pay or play" payroll taxes) that it finds do not violate ERISA. These policies would clarify for states how to craft their health care reform to comply with ERISA and would protect them from the burden and uncertainty of lawsuits. Oregon's Congressional delegation should partner with other reform-minded states to effectuate a "safe harbor" policy related to state health reform efforts.

16. Congress should amend ERISA to permit states to collect data from self-insured employers or their third party administrators concerning benefits received by employees and dependents residing in the state. The Department of Labor could develop criteria for a uniform set of data to collect with the assistance of the National Governors' Association.

17. Congress should consider the National Association of Insurance Commissioners' recommendation to grant the Secretary of Labor the authority to issue waivers from ERISA for states implementing comprehensive health reform proposals.

DRAFT

FEDERAL TAX BENEFITS RELATED TO HEALTH INSURANCE AND MEDICAL EXPENSES

RESULTS FROM HEARINGS AND RESEARCH: Federal income tax codes provide inequitable benefits around health care expenses, particularly health insurance premiums. Self-employed individuals and individuals buying health insurance on the open market are not able to obtain the same tax benefits as those receiving employer-sponsored health insurance.

BACKGROUND:
One goal of health reform in Oregon is to ensure that all Oregonians have access to affordable health insurance, regardless of whether that insurance is provided by employers or purchased by individuals on the open market. Currently, those purchasing insurance individually do not get federal tax benefits equivalent to individuals with employer-sponsored insurance.

Employer paid medical benefits, including health insurance premiums, flexible spending accounts, and health reimbursement accounts (including Section 125 plans), are not included as part of an employee's personal taxable income. Regardless of whether the individual chooses to itemize income deductions, these medical benefits are pre-tax. Employee contributions to health insurance premiums are made pre-tax.

One health reform strategy considered by states includes requiring all employers to offer Section 125 Premium Only Plans (POPs) to all employees (unless employers pay 100% of an employee's premiums). These plans allow employees to contribute pre-tax dollars to pay for their insurance premiums, and can be applied to employer sponsored insurance or to insurance purchased on the open market. Using pre-tax dollars saves individuals as much as 35 percent of their spending on health insurance premiums, depending on their income tax bracket. Section 125 POPs are not available to self-employed or unemployed persons.

Similarly, self-employed individuals may directly deduct amounts paid for health care insurance from their taxable income (whether or not the individual chooses to itemize his or her deductions). However, self-employed individuals face specific limits to their tax benefits that persons receiving employer-sponsored health insurance do not face. Self-employed individuals can only deduct premiums from their taxable income up to the total of their income from the trade or business less items such as the self-employment tax deduction and qualified pension contributions. Further, premiums can only be deducted for the months where they are not eligible for insurance through their employer (when the individual has a job as an employee as well as being self-employed) or through their spouse's employer.

Individuals purchasing health insurance on the open market receive the fewest federal tax benefits. An individual can deduct those medical and dental expenses (including insurance premiums) that are higher than 7.5 percent of adjusted gross income as an itemized deduction. Itemizing deductions is typically not preferable to the standard deduction for many individuals unless they own a home. There has been recent discussion in Congress about allowing this deduction directly, without itemizing. Expenses at or below 7.5 percent are not eligible for a federal tax deduction. In Oregon, individuals aged 62 and older can deduct the qualified

expenses below 7.5 percent from their Oregon taxable income, if they itemize their Oregon deductions.

Some individuals may qualify for a refundable tax credit against their federal tax due for 65 percent of the premiums they pay. This credit reduces their federal tax liability, and may provide a refund if a person's tax liability is low enough. To qualify, individuals must belong to a group specified in the 2002 law, including those who lost jobs due to the recession following the Sept. 11 attacks and those on premium assistance programs like FHIAP.

Employees, self-employed, and individuals purchasing insurance in the open market may also benefit from Health Savings Accounts (HSAs). These are tax exempt accounts used to pay for medical expenses, including insurance premiums. An HSA must be paired with a high deductible insurance plan, which typically has a lower premium than other plans. Contributions to HSAs are pre-tax when made by or through an employer, or post tax if made directly by the covered individual who may then receive a federal deduction from taxable income on their yearly tax return. Contributions are limited by federal law (2008 statutory limits are $2,900 individual and $5,800 family).

RECOMMENDATIONS:

18. Congress should modify the personal income tax code to provide equal tax benefits to all taxpayers purchasing health insurance, regardless of whether that insurance is purchased through an employer, as a self-employed person, or as an individual purchasing health insurance on the open market. Specifically, all taxpayers should be allowed to directly deduct health insurance premiums from their taxable income without having to itemize deductions.

19. In addition, Congress should modify the personal income tax code to offer low income taxpayers the choice of either the direct deduction for premiums (recommended above) or a refundable credit against their tax liability for health insurance premiums. This tax credit could be structured similarly to the Earned Income Credit, so that employed individuals receive the benefit of this credit at the time of each paycheck. Giving low-income taxpayers the choice of a credit would assist individuals in participating in state health reform efforts that include an individual mandate.

DRAFT

PROVIDER WORKFORCE and GRADUATE MEDICAL EDUCATION

RESULTS FROM HEARINGS AND RESEARCH: A robust, diverse health care workforce is critical to Oregon's ability to achieve the goals of the Health Fund Board, particularly related to creating an "integrated health home" for each Oregonian. However, current workforce projections indicate an impending shortfall of providers, especially in primary care fields.

BACKGROUND:

Oregon's Health Care Workforce: Oregon's health care workforce is not growing rapidly enough to meet the demand for care statewide, especially in rural areas and for primary care providers. Research indicates that Oregon needs 322 new physicians each year,[29] but the health care education system in our state is unable to meet this demand. The OHSU School of Medicine graduates approximately 120 medical students and trains 200 medical residents each year, many of whom leave Oregon when beginning their practice.[30] In addition, Oregon is continually losing physicians to retirement and increasingly insufficient Medicare reimbursement rates making a medical career less promising.[31] Beyond physicians, Oregon's demand for physician assistants, nurses, nurse practitioners, dentists, and dental hygienists are all increasing, and the rates that these workforces are growing is predicted to be insufficient to meet the need.[32] Oregon is not the only state facing steep shortages in the health care workforce as demand for health care is climbing. This trend is continuing across the country.[33]

Lack of Data on Oregon's Workforce: With the exception of the Oregon Board of Nursing, the state licensing organizations for health care professionals statewide do not collect data on many aspects of the health care workforce. The Board of Nursing's data, which includes the specializations of nurses and other details about their employment around the state, allows officials statewide to have a comprehensive picture of the areas where more nurses are needed most. To address this issue, the Oregon legislature requested that the Oregon Health Workforce Institute work with licensing boards to develop a plan to collect more detailed workforce data in Oregon. This data will be instrumental in achieving policy goals for Oregon's health care workforce and in directing resources and funds to areas where they can be most effective.

HRSA and Department of Labor programs: A variety of programs to offset the costs of health care workforce training are available through the Health Resources and Services Administration (HRSA) and the Department of Labor's Workforce Investment Act (WIA) as well as loan and scholarship. These are high-demand programs that help students in medical professions,

[29] Oregon Employment Department projections.
[30] Dr. Mark Richardson, Dean of OHSU School of Medicine, presentation to Federal Laws Committee April 22, 2008.
[31] Office of Oregon of Health Policy and Research, 2006.
[32] Oregon Health Care Workforce Needs Assessment 2006, www.QualityInfo.org.
[33] GAO Report, "Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services, February 12, 2008.

including nurses, physician assistants, and physicians pay for their educations each year. The 2009 federal budget proposed by President Bush includes approximately $1 billion in cuts to Workforce Investment Act programs, including those designated to help students in various health care education programs fund their training. In addition, the budget requests cuts of $557 million to various Health Professions programs under HRSA.

Medicare reimbursement for graduate medical education: Federal funding of graduate medical education directly through reimbursement via the Medicare program includes some complex facets. Reimbursement funds for residency slots were 'capped' at 1996 levels by Congress, called the "GME cap." Thus, a given hospital only receives the level of federal funding for residencies that they were allotted in 1996 regardless of whether more residency slots are created. Hence, federal funds for residencies do not increase along with the increased demand for physicians, presenting a barrier to increasing the pool of trained physician.[34] This is particularly hard on regions with high population growth and regions that did not have a large number of residencies in 1996. A hospital may trade slots back and forth between residencies at their institution, so long as they remain under the institutional cap. This gives older, larger hospitals (in 1996) more flexibility in moving residency program openings to specialties where there is demand. The Balance Budget Refinement Act of 1999 allows rural hospitals to apply for a 30% increase in their cap, but urban hospitals may not.

However, a Medicare funding loophole exists: the GME cap applies only to residency programs that were in existence in 1996. Newly developed residency programs do not have a cap on the number of residents eligible for federal funding. This loophole provides an opportunity for states to train new physicians if hospitals can be encouraged to undertake the expense and burden of implementing a new residency program. States can encourage these new residency programs with support and resources for start-up costs.

The Oregon Medicine Collaborative (ORMED) was developed in 2006 as a state university and regional health system partnership to improve regional distribution of physician training and physicians. This Collaborative seeks, in part, to increase residency training opportunities in rural and underserved communities in Oregon. Participants include the OHSU School of Medicine, University of Oregon at Eugene, PeaceHealth System-Oregon Region, Oregon State University and Samaritan Health Services. These partners share training facilities and research resources for medical education.

Robust Primary Care Workforce: In addition to physicians, physician assistants and nurse practitioners may provide primary care services. One method of addressing a primary care provider shortfall may be to focus attention on growing the non-physician workforce.

Nurse practitioners and physician assistants can see patients, diagnose, treat, prescribe medications, and refer patients to other providers. According to federal and state law, a physician must oversee physician assistants, while nurse practitioners can practice without physician oversight under certain circumstances under Oregon law. In particular, nurse practitioners can receive commercial and Medicaid reimbursement for treatments conducted

[34] Jordan J. Cohen, Association of American Medical Colleges, letter to Thomas Scully at CMS, January 25, 2002. http://www.aamc.org/advocacy/library/gme/corres/2002/012502.htm

without physician approval in Oregon,[35] and may prescribe medications as permitted by the Oregon Board of Nursing. However, federal CMS policy has more restrictive regulations, requiring nurse practitioners to have physician approval for treatment plans to receive Medicare reimbursement. This federal policy functions as a barrier to a more diverse primary care workforce in Oregon. Specifically, clinics would be unable to be staffed at any given time by nurse practitioners without a physician to approve treatment. This could restrict the development of new clinics, place unnecessary demands on physician staff to work nights and weekends and/or restrict the hours of operation for clinics that may otherwise be open during off hours.

RECOMMENDATIONS:

20. Congress should oppose any efforts to reduce federal funding for health care workforce education. Moreover, Congress should enhance such funding in select critical shortage areas.

21. Congress should raise the federal cap on Medicare funding for GME residencies. The current cap system is unfair to western states and the 1996 levels being used are unrealistic for today's physician training needs. The capping of graduate medical education reimbursements is an archaic policy that does not make sense in light of the current medical shortage faced by states. Congress should revisit these policies and allow established training sites to expand in Western states.

22. Congress and/or CMS should allow states to waive the CMS requirement for physicians to approve nurse practitioner treatment plans in order to receive CMS reimbursement. In states like Oregon, where nurse practitioners have independent practice authority, the federal government is demanding inefficient overlapping of resources by requiring physician oversight of nurse practitioners. This undercuts Oregon's ability to develop a diverse primary care workforce and overloads existing staff unnecessarily.

23. *STATE RECOMMENDATION: The Health Fund Board should support current plans to collect data on Oregon's health care workforce through state licensing agencies. Information about the existing workforce is instrumental to effective policymaking to improve workforce distribution and funding programs appropriately for our goals.*

24. *STATE RECOMMENDATION: Oregon legislators should fund the ORMED Collaborative to increase residency training opportunities in rural and underserved communities in Oregon. This effort can help avoid the GME cap by opening new residency training sites, deepen and diversify practice experiences, and may actually increase the number of rural practitioners. According to testimony heard by the Committee, practitioners often choose to stay in areas where they are trained.*[36]

[35] U.S. Department of Health and Human Services, Health Resources and Services Administration. http://www.hrsa.gov/reimbursement/states/Oregon-Medicaid-Covered-Services.htm
[36] Dr. Mark Richardson, Dean of OHSU School of Medicine, presentation to Federal Laws Committee April 22, 2008.

EMTALA and OREGON'S EMERGENCY DEPARTMENTS

RESULTS FROM HEARINGS AND RESEARCH: The key issues facing Oregon's Emergency Departments (EDs) appear not to be related to EMTALA. Instead these problems relate to a lack of health insurance and lack of access to primary care in the community. Further, testimony was largely supportive of EMTALA, and, even if changes were desired, waivers are not granted for EMTALA.

BACKGROUND: The Emergency Medical Treatment and Active Labor Act (EMTALA) was designed to prevent hospitals from transferring uninsured patients to public hospitals without first screening patients to ensure they were stable for transfer. Hospitals must treat patients presenting with emergency medical conditions regardless of their ability to pay. Due to EMTALA, people who lacked the ability to pay for primary care to treat and prevent conditions end up receiving treatment in hospital Emergency Departments once their conditions become severe. In many cases, these medical crises could have been prevented with earlier primary care.

The Committee heard arguments demonstrating the need for, and benefits of, EMTALA, and arguments against changing EMTALA. For example, despite EMTALA protections, patient harm has been documented in cases where patients were sent away from emergency departments. According to one presenter, only 12% of Emergency Department (ED) care could be provided in less acute settings, representing a small portion of healthcare costs. Another presenter testified that ED care represents a very small proportion of overall uncompensated hospital care – the greatest proportion included inpatient care for conditions not managed in the primary care setting.

None of the significant issues facing EDs heard by the Committee were due directly to EMTALA. Emergency Departments face severe overcrowding, lack of on-call specialists, inabilities to hold psychiatric patients for stabilizing in some cases, and other troubling issues. One of the main concerns, overcrowding, would likely be significantly alleviated by increasing the use of primary and preventive care. If health care reform in Oregon successfully reduces uninsurance, transforms the health care delivery system to include an integrated health home, and increases the size of Oregon's primary care provider workforce, some of the issues facing EDs would be alleviated.

One concern about EMTALA presented to this Committee involved how EMTALA has been implemented by Oregon's hospitals. In particular, some hospitals may not transfer patients needing specialist care to another hospital in the region with better qualified specialists due because of a concern of being found in violation of EMTALA.

RECOMMENDATIONS:

25. *STATE RECOMMENDATIONS: The Committee agreed with presenters that EMTALA is an extremely important protection. Although this Committee did not identify any recommendations regarding EMTALA at the federal level, the Committee did identify two issues for state consideration:*
    a. *Further study is necessary on the potential for alleged EMTALA violations arising from inter-hospital transfers based on the availability of appropriately*

trained physicians. Further study may be of benefit to examine whether EMTALA could be more effectively operationalized in Oregon.

b. *According to testimony, some Oregon hospitals lack the ability to place involuntary psychiatric holds on patients due to DHS facility requirements, causing some patients to be released against the advice of the hospital. The Committee has referred this issue to the Health Fund Board and to DHS for further inquiry. See Appendix B for a copy of this referral memorandum.*

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HIPAA

RESULTS FROM HEARINGS AND RESEARCH: HIPAA does not currently present a barrier to coordination of care and sharing patient information between providers. The implementation of privacy practices and misunderstanding of privacy laws at a clinical level may, however, present an operational barrier to coordinating care and sharing information.

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) includes requirements for ensuring the privacy and security of patient information. Health plans, clearinghouses, and providers must comply with privacy rules around release of individually identifiable health information. In particular, providers must "provide notice of privacy policies and procedures to patients, obtain consent and authorization for use of information and tell how information is generally shared and how patients can access, inspect, copy and amend their own medical record."[37] Under HIPAA, health care providers and insurers may disclose protected health information without patient authorization or other permission if the disclosure is for purposes of treatment, payment, and health care operations.

Because HIPAA allows treating providers to exchange patient information without a patient's consent, the law does not present a barrier to coordinating care. However, this Committee heard testimony that many providers, clinics, and hospitals' policies require such consent prior to treatment. These privacy policies may be based on an incorrect understanding of HIPAA – fearing that to share information without patient consent would be a HIPAA violation. These facilities spend considerable time and staff resources complying with their internal privacy policies. Educating providers about what types of information exchange is permitted under HIPAA may lead to savings in administrative resources.

HIPAA may present challenges to a new system of electronic personal health records that are under the control of the individual, but these legal challenges are not well defined at this stage. Oregon's Health Information Infrastructure Advisory Committee (HIIAC) will develop a strategy for "the implementation of a secure, interoperable computerized health network to connect patients and health care providers across Oregon." The HIIAC will hold their first meeting April 2008. Until such a strategy is well defined, specific recommendations relating to HIPAA law cannot be adequately developed.

RECOMMENDATION:

26. *STATE RECOMMENDATION: Although this Committee did not identify any recommendations regarding HIPAA at the federal level, the Committee did identify an issue for state consideration: There is a misunderstanding among providers concerning HIPAA requirements around the exchange of patient information. In particular, providers may be able to reduce administrative burden if they are aware that HIPAA allows treating providers to exchange patient information without written patient consent. DHS should consider conducting a provider education effort to clarify HIPAA requirements.*

[37] HIPAA Background from Oregon Association of Hospitals and Health Systems.

INDIAN HEALTH SERVICE TRIBAL AND URBAN PROGRAMS

RESULTS FROM HEARINGS AND RESEARCH: Oregon's American Indian/Alaskan Native (AI/AN) population is highly underserved and suffers significant health disparities, due, in part, to low federal funding. The Health Fund Board's efforts to provide affordable health insurance should help AI/AN individuals greatly. However, the Board and Oregon legislators must recognize the implications of the unique relationship between Tribes and the US government when designing a health reform plan.

BACKGROUND:
Oregon is home to 9 federally recognized Tribes and counts more than 90,600 American Indian/Alaskan Native individuals in its population.[38] Oregon's Tribal health system provides care to more than 47,000 people and 7,000 people receive services through Oregon's Urban Indian Program housed in Portland.

American Indian/Alaskan Native people in Oregon and nationwide suffer enormous health disparities. For example, a 2001 study found that, nationally, the American Indian/Alaskan Native population had more than three times the number of deaths per 1,000 related to diabetes, and more than seven times the number of deaths per 1,000 related to chronic liver disease. The national infant mortality rate for American Indian/Alaskan Natives is 204 infants per 1,000 compared to 87 infants per 1,000 in the non-Indian population.

Unlike other racial or ethnic minority groups, Tribes are sovereign entities with a unique relationship directly with the United States government. States have no inherent right to regulate Tribes. The United States has a federal obligation to provide health services to American Indian/Alaskan Native people. Until 1975, the federal government provided these services directly through Indian Health Service (IHS) programs. Starting in the mid 1970s, several laws were passed directing IHS to turn over operating funds to Tribes who wished to take over the provision of these services (under Title I of the Indian Self-Determination and Education Assistance Act), and allowing Tribes the flexibility to allocate funds as they saw fit (under Title V, the "self-governance program"). In Oregon, all nine Tribes have taken over at least some provision of services and/or governance of funds from IHS: four Tribes have Title I contracts with IHS and five Tribes have Title V compacts for self-governance. Research comparing services provided directly by IHS to services provided by Tribes found that often Tribes are able to provide more services, create more new facilities, create operational efficiencies, maximize third party reimbursement, and achieve improved quality of care.[39]

Oregon's American Indian/Alaskan Native (AI/AN) populations receive health care coverage through several mechanisms. Approximately 3 percent of AI/AN individuals in Oregon are enrolled in the Oregon Health Plan and/or Medicare (compared to approximately 27% of all Oregonians). Although some AI/AN individuals have commercial insurance through an

[38] US Census Bureau, State Population Estimates, July 2007.
[39] "Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management," National Indian Health Board, 1998.

employer or purchased directly, the number of uninsured in this population is high. In 2006, the Oregon Population Survey found that 28.6 percent of AI/AN individuals in Oregon were uninsured, compared to 15.6 percent uninsured across all groups in the state. Anecdotal estimates place the number of uninsured in Tribes as much higher, especially given the survey bias to higher income homes with phones. Research indicates that 32 percent of AI/AN homes nationwide do not have phones.[40]

Tribes provide health care directly through IHS programs carried out by Tribal clinics and contractors. Tribal health service providers can receive reimbursement from Medicare, Medicaid, and commercial insurance plans (if the provider is in the plan's provider network). For uninsured patients, services are paid by federal IHS funds delegated to the Tribe. The federal government provides Tribes with the amount of funding that the federal Indian Health Service would have spent directly serving the Tribes, divided by the category of spending (e.g., hospitals). Each category's funding level is based on a formula that considers the number of individuals in the Tribe and the health status of the Tribal population. All services contracted out by Tribes are paid through IHS's Contract Health Services Program (CHS). In Oregon, all Tribal health system services are contracted and paid with CHS funds. The total CHS funds for the US are limited, so each Tribe receives their share of the funds.

Limited federal funding for Indian Health Service programs, whether operated by IHS or by Tribes, is roundly considered the largest barrier to achieving health equities for Tribes. IHS funding was $2,100/person in 2005 – compared to more than twice that for Medicaid beneficiaries and more than three times that for Medicare beneficiaries. Tribes receive their IHS funding at the beginning of the federal fiscal year. According to testimony received by this Committee, Contract Health Services funds run out before the end of the year. When CHS funds get low, IHS services move from a "Priority II" level to a "Priority I" level where services must pass a "life or limb" test. Most Tribes collect a backlog of non-emergency services for the start of the fiscal year, and quickly spend down to a Priority I level. Some Tribes are able to supplement IHS funds to cover the gap.

Unlike services provided to other Medicaid beneficiaries, Tribal services provided to an AI/AN individual enrolled in Medicaid receive full payment from CMS (called 100% federal match) without any matching state payment.[41] Because of this, Oregon Tribes have requested open or preferential access to enrollment in Oregon Health Plan Standard, which is currently closed to new enrollees. DHS is in the process of reviewing this request. Further, Oregon has requested an amendment to its Oregon Health Plan waiver, to allow AI/AN individuals who are eligible for the OHP Standard benefit package to receive the OHP Plus benefit package. This request has been pending with CMS since 2002. Both of these requests would greatly increase the number of AI/AN individuals in Oregon with coverage for their health care needs.

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[40] US Census Bureau, "United States Summary 2000: *Summary Social, Economic, and Housing Characteristics*." See Table 75: Selected Equipment Characteristics of Housing Units With an American Indian and Alaska Native Householder (One Race): 2000," pp. 449-455.

[41] 100% federal match applies only to services provided by Indian Health Service facilities and Tribal clinics. Urban Indian Health Clinics are not matched at 100%, neither are Medicaid services provided outside IHS facilities or Tribal clinics.

RECOMMENDATIONS:

27. Given the unique relationship between Tribes and the Federal Government and the US government's responsibility to provide health care to all Tribal members, Congress should adequately fund Tribal health services.

28. CMS should approve Oregon's waiver request to allow AI/AN enrollees in OHP Standard to receive OHP Plus benefits. This waiver request has been pending since 2002.

29. *STATE RECOMMENDATION: The Oregon Health Fund Board and the Oregon legislature should endeavor to consider the unique "federal trust relationship" between the United States and Indian Tribes, which creates a federal obligation to provide health services to American Indian/Alaskan Native people. When considering significant changes to public health benefits and the use of managed care organizations to provide care any impact on this special relationship must be considered. A letter to the Health Fund Board from the Northwest Portland Area Indian Health Board points out several areas for the Board to consider:*
    a. *Reform initiatives must be consistent with the federal government's responsibility to Tribes*
    b. *The 100% federal match for Medicaid services provided by or through IHS or Tribal programs must be factored when determining benefits and reimbursement methods.*
    c. *Eliminate or waive American Indian/Alaskan Native Medicaid and Medicare beneficiaries of all cost sharing.*
    d. *Any benefit packages for American Indian/Alaskan Native Medicaid beneficiaries should be equivalent in amount, duration or scope as the best benefit package offered to Medicaid beneficiaries in Oregon*
    e. *Managed care: American Indian/Alaskan Native individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer and not be involuntarily assigned to a non-Indian managed care plan when an Indian health program is available. Further, managed care plans or contractors should be required to pay Indian health providers even if these providers are "out-of-network"*
    f. *Respect for cultural beliefs and traditional practices. CMS should include access to traditional medicine as part of services available to American Indian/Alaskan Native people.*
    g. *Simplify and improve access to Medicaid eligibility.*

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NEW FEDERAL GRANT PROGRAM TO SUPPORT STATE REFORM

RESULTS FROM HEARINGS AND RESEARCH: The current health care system is in crisis. There is much interest at the state and national level in reforming health care and decreasing the number of uninsured Americans. There have been a few, targeted pilot programs related to health reform (including a medical home model grant) funded by CMS, but Congress has not created a federally funded demonstration grant program to support state reform efforts.

BACKGROUND: There has been national interest in a federal grant program to support states' health reform efforts. In 2007, the National Association of Insurance Commissioners recommended that Congress create a grant program for state health reform efforts.[42] There have been several bills introduced in Congress as well (none of which has yet made it to a vote):

- In January 2007, the Health Partnerships bill was introduced as Senate bill 325 and House Resolution 506 (with 80 cosponsors). The bills would provide for innovation in health care through State initiatives that expand coverage and access and improve quality and efficiency in the health care system.
- In September 2007, US Sen. Sanders (VT) introduced Senate bill 2031 to provide demonstration project grants and flexibility to states to provide "universal, comprehensive, cost-effective systems of health care coverage, with simplified administration."
- In April 2007, Senator Feingold introduced Senate bill 1169, to "ensure the provision of high quality health care coverage for uninsured individuals through state health care coverage pilot projects that expand coverage and access and improve quality and efficiency in the health care system."

RECOMMENDATION:

30. Congress should create a federal grant program to support states pursuing innovative reform concepts. Members of Oregon's Congressional delegation should consider sponsoring or supporting such a bill.

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[42] "NAIC Recommendations for Federal Action," Federal Relief Subgroup, State Innovations (B) Working Group, National Association of Insurance Commissioners, May 2007.

APPENDIX A

HISTORY OF THE OREGON HEALTH PLAN (OHP) [43]

1988 – Senate President John Kitzhaber initiated the Oregon Medicaid Priority Setting Project, which laid the groundwork for the Prioritized List of Health Services.

1989 – The Legislature developed a framework for Phase I of the OHP Medicaid demonstration.

1991 – Phase II of the OHP Medicaid demonstration was developed, which included preparations to offer mental health and chemical dependency services.

- The Health Services Commission recommended its first Prioritized List to Governor Roberts and the Legislature.
- Oregon sent its Medicaid waiver application to the US Health Care Financing Administration (HCFA).

1992 – HCFA denied Oregon's waiver application because of possible violations of the Americans with Disabilities Act.

- The Health Services Commission revised the prioritization methodology and resubmitted the waiver application to HCFA, which is subsequently approved.

1993 – The Legislature passed a funding package for Medicaid expansion using General Funds, a 10-cents-per-pack cigarette tax increase, and federal matching funds.

- HCFA approved the initial Prioritized List, which included coverage for mental health and chemical dependency services.
- The Legislature created the Office of the Oregon Health Plan Administrator.

1994 – Oregon Health Plan begins full operation

- Medicaid eligibility was expanded to include Oregonians below 100% of the Federal Poverty Level (FPL).

1995 – The OHP Basic benefits package is expanded to include Medicaid seniors, people with disabilities, and children in foster/substitute care.

- The Legislature approved premiums and $5,000 liquid asset eligibility test for new OHP beneficiaries.

1997 – All OHP beneficiaries deemed eligible for expanded mental health benefits provided through mental health organizations (MHOs).

- The Family Health Insurance Assistance Program (FHIAP) is created to help low-income, working people pay for private health coverage.
- The Office of Oregon Health Plan Administrator is renamed the Office for Oregon Health Plan Policy Research (OHPPR).

[43] Oregon Health Plan: an historical overview. Department of Human Services

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1998 – The OHP Basic benefit package expanded to include pregnant women with income up to 170% FPL.

- The State Children's Health Insurance Program (SCHIP) began for uninsured children and OHP eligibility rose to 170% FPL for these children.

1999 – The Legislature lowered the liquid asset test to $2,000.

2001 – The Legislature requested new Medicaid waivers to change the benefit package for some OHP beneficiaries and to use the savings to pay for an expansion of eligibility up to 185% FPL. In addition, the waiver requested that federal funding be used to expand coverage to more people in FHIAP.

2002 – The Emergency Board of the Legislature approved the OHP2 waivers with incremental expansion of Medicaid to 115% FPL and expansion of FHIAP.

- DHS submitted its second 5-year OHP project waiver request to Centers for Medicaid services (CMS, formerly HCFA); CMS approved the waivers.
- The Disease Management Program begins, targeting clients with specific health conditions and providing case management

2003 – Copayments were instituted for most adult fee-for-service clients (with exemptions for pregnant women, tribal clients, and long-term care clients receiving waivered services).

- Covered services on the Prioritized List drop from line 566 to 549; the Medically Needy and General Assistance programs were discontinued; long-term care at lesser-impaired Survivability Levels 12-17 lost eligibility.
- The OHP Basic package was renamed to OHP Plus; a new benefit package, OHP Standard, is created. OHP Standard included reduced benefits, higher copayments, and premiums.
- OHP eligibility for pregnant women and children rose to 185% FPL.
- Medicaid managed care plan and hospital provider taxes established by the Legislature.

2004 – Ballot Measure 30 failed, which necessitated an OHP benefit reduction and curtailed OHP Standard enrollment.

- A court order directed DHS to end copayments for OHP Standard beneficiaries.
- OHP Standard closed to new enrollment.

2005 – OHP Standard beneficiaries below 10% FPL exempted from paying premiums.

2006 – SCHIP beneficiaries' eligibility is extended from 6 to 12 months.

2007 – The Legislature passes SB 329, which established the Oregon Health Fund Board and its committees to propose large-scale reform to Oregon's healthcare system.

- The Oregon Health Fund Board and committees begin holding meetings.
- CMS extended Oregon's OHP2 waiver for another 5 years.

2008 – OHP Standard reopened enrollment for 3,000 – beneficiaries chosen by lottery and 91,000 Oregonians entered the lottery for the opportunity to apply for the 3,000 spots.

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APPENDIX B

MEMORANDUM

TO: Bill Thorndike, Chair, Oregon Health Fund Board
Bruce Goldberg, Director, Oregon Department of Human Services

FROM: Dr. Frank Baumeister, Chair, Federal Laws Committee of the Oregon Health Fund Board

DATE: TBD

RE: Hospital involuntary psychiatric holds and EMTALA

The Federal Laws Committee has become aware of a conflict between the EMTALA requirement that the hospital and treating physician stabilize patients before transfer or discharge and the state DHS policy that prohibits hospitals from placing involuntary psychiatric holds unless the hospital has met certain DHS facility requirements.

When psychiatric patients arrive at the Emergency Department and do not wish to remain for treatment, the county mental health agency has the authority to place an involuntary hold if the patient is deemed a threat to themselves or others. If the county disagrees with the hospital or treating ED physician's medical advice to hold the patient, the patient must be released unless the hospital is certified by DHS to place its own involuntary hold. In several cases presented to the Committee, these released patients unfortunately committee suicide.

Although the hospital and treating physician would not be liable under EMTALA for failing to stabilize a patient (since patients can leave against medical advice), this Committee heard testimony that DHS certification rules may be too strict for smaller and rural hospitals.

The Committee recommends that hospitals and DHS work together to resolve this issue. The solution may include working with uncertified hospitals to become certified and/or revising DHS policy to allow certification for these hospitals.

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