

Oregon Health Policy Board

AGENDA

April 2, 2013

Market Square Building
1515 SW 5th Avenue, 9th floor
1:00 to 4:00 p.m.

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll Action item: Consent agenda: 3/5/13 minutes		
2	1:05	Director's report and legislative update	Bruce Goldberg	
3	1:20	Update on Transformation Center	Cathy Kaufmann	
4	1:35	Workforce Committee report back	Lisa Dodson, Committee chair Ann Malosh, Committee vice-chair	X
	2:20	Break		
5	2:35	Reinsurance report: ACA impacts on individual and small market	Barney Speight	
6	3:45	Public Testimony	Chair	
	4:00	Adjourn		

Next meeting:

May 5, 2013

8:30 a.m. to noon

Market Square Building

1515 SW 5th Avenue, 9th floor

Oregon Health Policy Board
DRAFT Minutes
February 5, 2013
1 pm to 4 pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Carlos Crespo.

Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA).

Consent Agenda:

The minutes from the January 8, 2013 meeting were unanimously approved.

Director's Report and Legislative Update – Bruce Goldberg

Bruce Goldberg gave a CCO update, stating that many of the CCOs have spent the last six months working on the administrative side of their organizations. He said there have been a lot of successes and what he is sensing now is greater attention being paid to how care is delivered.

Goldberg also gave an update about the current legislative session. He said expanding coverage through the Affordable Care Act will help us continue on this journey of health system transformation: "You can only fix a system that has people in it." Goldberg said some other key pieces of legislation include loan repayment, liability reform, and the budget. He said the budget is important because it will fund our Medicaid program at our agreement with the feds and make a substantial investment in community mental health and addictions treatment.

Federal Health Reform – Gretchen Morley, Elizabeth Lukanen, Julie Sonier, Peter Graven

Gretchen Morley spoke about the Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Patient Protection and Affordable Care Act. Morley said the Expansion includes adults ages 19 to 64 with incomes at or below 138% of Federal Poverty Level. She said states will receive 100% federal funding for the "newly eligible" population from 2014 through 2016, phasing down to 90% in 2020 and beyond.

Morley said the analysis was a collaboration between the State Health Access Data Assistance Center (SHADAC), Oregon Health Science University's Center for Health Systems Effectiveness (CHSE), and Manatt Health Solutions. Its focus was the financial effects of implementing the Medicaid expansion, not the fiscal impacts of other mandatory components of the ACA.

Summary of Oregon Medicaid Expansion Analysis:

- Approximately 260,000 Oregonians will gain access to care through the Oregon Health Plan (OHP)
 - Approximately 240,000 newly eligible and 20,000 previously eligible individuals
- \$11.3B in new federal Medicaid spending (2014-2020)
 - \$10.2B for new coverage
 - \$1.1B funding for OHP Standard and select other current Medicaid eligibles at the enhanced match rate
- \$79M net savings to state general fund (2014-2020)
 - \$591M in spending on new coverage

- \$321M in GF savings due to enhanced federal match from transitioning some Medicaid adults into the “newly eligible” group and reduced state costs to serve the uninsured and cover state employees and educators; and
- \$350M in tax revenue due to increased economic activity.

Estimated Financial Effects of Expanding Oregon’s Medicaid Program can be viewed [here](#), starting on page 7.

Update on CCO Transformation Plans – Leslie Clement

Leslie Clement gave an update on the status of CCO Transformation Plans. She said elements of the Plans include integration, patient-centered primary care homes, alternative payment methodologies, community assessments, health information technology, member engagement, provider and cultural competency, and a quality improvement plan that focuses on eliminating disparities.

Clement spoke about the contract amendment template that focuses on memorable and meaningful benchmarks. She said the amendment will eventually become the CCO’s contract. Clement also said in the narrative section of the Plan, CCOs were encouraged to describe other transformational activity and innovative approaches.

Draft Transformational Plans were due January 15. Clement said no two plans were alike; they ranged significantly, which was not a surprise. She said a core team of OHA staff scheduled calls with all of the CCO executive teams to give them standardized direction regarding the number of benchmarks.

Clement said initial feedback in writing was given to the CCOs on Feb. 1 and final Plans are due on Feb. 15. The provisional approval process starts on March 1.

ELC/OHPB Joint Subcommittee Update – Dana Hargunani, Carla McKelvey

Carla McKelvey gave an update on the Early Learning Council and OHPB Joint Subcommittee. She said at the latest meeting, the group reconfirmed its principles and priorities. McKelvey said they talked about levers for coordination and alignment, including governance and accountability, funding, community assessments, and technical assistance for CCOs and Hubs. McKelvey also said the group focused on developmental screening.

Dana Hargunani spoke about the short timeline, stating that recommendations will be made at the next subcommittee meeting.

ELC and OHPB Subcommittee meeting [agendas and materials](#) can be viewed [here](#).

Workforce Committee: Recommendations and Discussion – Lisa Dodson, Ann Malosh

Lisa Dodson spoke about the 2012 Recommendations from the Oregon Healthcare Workforce Committee. Dodson said the committee’s report includes recommended strategies, actions and policy changes that support the recruitment, retention and distribution of Oregon’s health care workforce, with an emphasis on primary care.

Ann Malosh spoke about the Committee’s priorities:

- Prepare the workforce for new models of care delivery.
- Improve the capacity and distribution of the primary care workforce.
- Use education, training and regulatory reform to advance towards the projected workforce need in 2020.

Malosh also summarized the Committee’s recommendations:

- Coordinate state and federal resources for health care occupations education, creating a “grow our own” strategy with a coherent pipeline and clear career pathways.
- Accelerate and spread payment reform as well as innovative delivery system models.
- Build evidence about the workforce implications of health care transformation to inform training

content and refine projections of future workforce demand.

- Expand health care workforce data collection and analysis for a more complete picture of Oregon's current health care workforce and future needs.

Board requests for future discussion:

- Clearly state what we are trying to accomplish around the triple aim and how we are going to accomplish it.
- Retention issues beyond payment reform.
- Concrete strategy for how to diversify workforce.
- Licensing and scope of practice.

Chair Eric Parsons asked the Workforce Committee to present "What (in relation to transformation goals), by When, and by Whom" at the April board meeting.

The Oregon Healthcare Workforce Committee can be viewed [here](#), starting on page 25.

Public Testimony

The board heard testimony from one person:

Jenifer Valley, Stoney Girl Gardens, spoke about safe access points for medical marijuana. She said her medical marijuana club has dramatically improved the health of cancer patients, including end-of-life patients and minor patients. Valley said medical marijuana impacts on the drivers of primary health costs are amazing.

Adjourn

Next meeting:

March 5, 2013

8:30 a.m. to 12 p.m.

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

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Oregon Health Policy Board

DRAFT Minutes

March 5, 2013

8:30 to 11:45 a.m.

Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, except Brian DeVore.

Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA).

Consent Agenda:

The minutes from the February 5, 2013 meeting were unanimously approved, pending the addition of Workforce Committee assignments.

Director's Report – Bruce Goldberg

Bruce Goldberg gave a legislative update, describing an overview of Affordable Care Act implementation. He said the ACA allows for coverage expansion for low income adults up to 138% of poverty level in 2014 as well as enhanced federal funding for those who are newly eligible.

Goldberg spoke about Oregon's Strategic Approach to implementing federal health reform. He said instead of the traditional budget balancing act of cutting people, cutting services and cutting provider rates, Oregon is changing how care is delivered by reducing waste, improving health, creating more local accountability, aligning financial incentives and creating fiscal sustainability.

Goldberg also spoke about statutory changes proposed this legislative session:

- HB 2859: Alignment of state law with changes to federal Medicaid and Children's Health Insurance Program Laws
- HB 2091: Transition children under 300% (FPL) to the Oregon Health Plan and phase out Healthy Kids Connect program
- HB 2240: Aligns Oregon insurance law with federal law
- OMIP Reform: Restructure OMIP to stabilize individual insurance market, help make insurance more affordable to individuals and encourage
- HB 2216: Repeals sunset on hospital assessment and allows it to continue for 2 years
- SB 568: Extends dispute resolution and par/non-par in OHP
- SB 440: Primary care loan repayment
- SB 483: Liability reform
- HB 2090: Integrates management of mental health drugs into PDL

Tina Edlund gave an update about the State Innovation Model grant. She said Oregon was one of six states that were awarded the grant. Edlund said the grant will be used to support Transformation efforts and "it's going to allow us to bring more to the table."

The OHPB Legislative Update can be viewed [here](#).

Oregon Health System Transformation Metrics – Lori Coyner

Lori Coyner spoke about quality and accountability measures preliminary baseline data. Coyner said CCO incentive measures include an annual assessment of CCO performance on 17 measures, which compare performance in 2013 to the 2011 baseline. She said quality pool funds will be available to CCOs based on

performance. Coyner said the state performance measures will include an annual assessment of statewide performance on 33 measures that will compare performance during July 2013 to June 2014 to the 2011 baseline. She also said there will be financial penalties to the state if quality goals are not achieved.

Coyner spoke about the baseline process and timeline:

- March 8th: OHA provides each CCO with preliminary baselines and technical specifications for 11 of 17 incentive measures that come from administrative or other readily available data.
- CCOs will have 30 days to review preliminary baselines and specifications and provide any feedback to OHA.
- End of May: OHA will provide each CCO with preliminary baselines and technical specifications for the remaining six incentive measures that require chart review or other data collection.
- CCOs will then have 30 days to review preliminary baselines and specifications and provide feedback to OHA.
- End of July – OHA will review and incorporate CCO feedback and publish final baselines for all 17 incentive measures.

Coyner also presented draft state-level baseline data for Calendar Year 2011. She said the baselines are pending additional review and validation from Oregon Health Care Quality Corporation and represent benchmarks that were established by the OHA Metrics & Scoring Committee and through negotiation with CMS in late 2012. The baseline data includes

- Improving Behavioral and Physical Health Coordination
- Improving Perinatal and Maternity Care
- Reducing Preventable Re-Hospitalizations
- Improving Primary Care for All Populations
- Reducing preventable and unnecessarily costly utilization
- Addressing Population Health Issues
- Ensuring Appropriate Care is Delivered in Appropriate Settings
- Addressing Patient Satisfaction with Health Plans
- Meaningful Use

Coyner said next steps include finalizing CCO incentive measure baselines between April and July 2013, providing technical assistance through the Transformation Center to improve coding for some measures, finalizing the CCO dashboard template, and developing resources through the Transformation Center to assist CCOs and providers improve in areas related to measures.

The presentation on Quality and Accountability Measures Preliminary Baseline Data can be viewed [here](#).

Churn Analysis: Enrollment Dynamics Between the Oregon Health Plan and Cover Oregon - Jeanene Smith, Shannon McMahon

Jeanene Smith gave a presentation on the Churn Analysis: Enrollment Dynamics Between the Oregon Health Plan and Cover Oregon. Smith said the goals of the analysis were to estimate potential magnitude of churn and identify implications and options for Oregon. She said reasons for studying the churn include important differences between Medicaid and private coverage in terms of benefits, premium level and cost sharing responsibility and disruptions in coverage and/or lack of care coordination across transitions could result in unmet needs.

Smith said currently Oregon administrative data show that about 46% of OHP clients remain in the same eligibility group after 12 months and based on Oregon experience, streamlining redetermination procedures improves retention.

For those initially under 138% FPL who do experience an increase in income, Smith said projections suggest that about 19% will gain commercial coverage through the Exchange.

Smith said an estimated 60,000 income-related Medicaid-QHP transfers will happen annually by 2016, which includes approximately 35,500 from Medicaid to Commercial and approximately 24,000 in the other direction.

Next steps include three key areas for more focused work:

- Assess likely health needs of the estimated 60,000 individuals who will transfer between CCOs and QHPs, in the context of benefits available to them
- Explore contractual alignment for CCOs and QHPs to smooth transitions
- Investigate bridge program and wrap-around options in terms of costs, efficiency, and likely outcomes

The Churn Analysis presentation can be viewed [here](#).

ELC/OHPB Joint Subcommittee Update – Dana Hargunani, Carla McKelvey

Dana Hargunani presented the ELC/OHPB Joint Subcommittee recommendations. She said the subcommittee has ongoing work but tight timelines made it necessary to present some initial recommendations to the Board.

Recommendations:

1. The Joint Subcommittee recommends that Coordinated Care Organizations (CCOs) and their Community Advisory Councils (CACs) work with their local early learning Hubs to develop a joint community needs assessment and community improvement plan beginning no later than 2015.
2. The Joint Subcommittee recommends that CCOs and Hubs identify best approaches to provide joint care coordination/case management for targeted children and families.
3. The Joint Subcommittee recommends that a member of local early learning Hub(s) be appointed to the local CCO(s) governance structure.
4. The Joint Subcommittee recommends that a statewide measure for developmental screening be established that accounts for screening to occur across early learning and health systems
5. The Joint Subcommittee recommends that the Transformation Center be a resource for building alignment between health and early learning at the local level, including but not limited to: shared outcomes, accountability and technical assistance.

The Board requested clarification regarding cross governance in Recommendation #3, as it does not explicitly state that Hubs will incorporate CCOs into their advisory committee structure as well.

Carla McKelvey moved to approve the ELC/OHPB Joint Subcommittee recommendations with clarification on Action Item #3. Carlos Crespo seconded the motion. VOTE: 8-0-1 Excused: Brian DeVore

The ELC and OHPB Subcommittee Recommendations can be viewed [here](#).

Public Testimony

The board did not hear any public testimony.

Adjourn

Next meeting:

April 2, 2013

1 to 4 p.m.

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

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MEMO

To: Oregon Health Policy Board

From: Oregon Healthcare Workforce Committee

Date: March 28, 2013

Action items: Accept attached revised 2012 report from the Workforce Committee; approve or decline to approve specific recommendations; direct or encourage Workforce Committee or other entities to move forward with implementation of approved recommendations.

About the report: The Healthcare Workforce Committee is required by its charter to produce a biennial report for the OHPB with “recommended strategies, actions and policy changes ... that support the recruitment, retention and distribution of Oregon’s health care workforce, with an emphasis on primary care.” The attached report contains the Committee’s *revised* 2012 recommendations in response to this charge. Two stakeholder comments on the Committee’s draft recommendations are attached in a separate document.

Feedback on first draft of this report: Draft recommendations were presented to the OHPB on February 5, 2013. Board members gave feedback on the draft material and requested that the Committee revise its analysis and recommendations to answer two specific questions:

1. What can the state do now to get ready for 2014? (What three or four key actions could be taken now that will help prepare the workforce for the influx of newly insured?)
2. What key actions should the state be considering for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation?

Board members encouraged the Committee to identify and prioritize actions that would be reasonably achievable and produce the greatest impact, and to focus on workforce needs within a transformed delivery model.

About the new recommendations: The Committee generated a number of recommendations in response to the two questions above. Among those, members prioritized four immediate steps that can increase primary care workforce capacity for 2014, as well as six actions that can be taken over a longer time frame. All the recommendations are listed in priority order in a one-page table and described more fully in the attached revised report.

- The short-term recommendations consist of actions with the potential for an immediate return: strategies for maximizing existing in-state workforce capacity, for recruiting already-trained professionals to Oregon and distributing them appropriately, and for increasing provider retention over the next few critical years.
- The longer-term recommendations are more varied and cover education, recruitment, retention, and data.
- All the recommendations focus on primary care, both because Committee members believe that will be the greatest need in 2014 and because robust primary care is at the heart of the coordinated care model and Oregon’s plans to achieve the Triple Aim.

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Oregon Healthcare Workforce Committee – Revised Recommendations Summary – April 2, 2013

Short-term recommendations to increase primary care capacity in advance of 2014		Category
1	Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible.	Maximize current capacity
1	Implement new Medicaid loan repayment program for primary care providers	Recruitment
3	Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care.	Data
4	Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.	Maximize current capacity
•	Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives.	Recruitment
•	Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a means of providing practice support to encourage providers near retirement to stay in the workforce a few years longer	Recruitment / retention
•	Make naturopaths eligible for the new Medicaid state loan repayment program.	Maximize current capacity
•	Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices	Retention
•	Continue active outreach for the J-1 visa waiver program, to increase the number of obligated	Recruitment
Administrative and programmatic recommendations for 2014 and beyond		
1	Re-fund the state's Primary Care Loan <i>Forgiveness</i> Program	Recruitment
2	Develop occupational training programs to respond to emerging care models and industry demand	Education
3	Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess	Data
3	Enact workforce data reporting mandate for all health profession licensing boards	Data
5	Develop integrated health careers pathways, with central coordination	Education
6	Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information	Education
•	Revise state's Adverse Impact law and related regulations	Education
•	Maximize opportunities for license reciprocity	Recruitment
•	Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners	Recruitment
•	Adopt a uniform credentialing system statewide, in alignment with Health Leadership Council work	Recruitment / retention
•	Develop a system for creating "workforce impact statements (i.e., statements of workforce needs generated by implementation of reform proposals)	Data
Additional recommendations for primary care capacity		
1	Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually.	Education
2	Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.	Education

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Oregon Healthcare Workforce Committee

***Revised* recommendations for the
Oregon Health Policy Board**

April 2, 2012



Preface

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee (“Committee”) to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. Among other things, the Committee is charged with producing a biennial report for the OHPB outlining “recommended strategies, actions and policy changes ... that support the recruitment, retention and distribution of Oregon’s health care workforce, with an emphasis on primary care.” A draft set of recommendations was presented to the OHPB on February 5, 2013. Board members felt that the recommendations needed more focus and asked the Committee to prepare revised recommendations in answer to two key questions:

1. What can the state do now to get ready for 2014? (What three or four key actions could be taken now that will help prepare the workforce for the influx of newly insured?)
2. What key strategies should the state be considering for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation?

This document contains the Committee’s revised recommendations in response to the Board’s direction. All the recommendations focus on primary care, both because Committee members believe that will be the greatest need in 2014 and because robust primary care is at the heart of the coordinated care model and Oregon’s plans to achieve the Triple Aim.

Because healthcare workforce issues lie at the intersection of education and health care policy, a particularly wide range of actors is implicated in the Committee’s recommendations. It is important to note, however, that the Committee’s ability to take direct action is limited: it does not have the authority to compel any other body to take action; nor does it have funding to implement ideas that may require financial or other resources beyond staff support. The Committee relies on the OHPB, the Oregon Health Authority, and the Governor’s office to carry many of its recommendations forward.

Short-term recommendations to increase primary care capacity in advance of 2014

The OHPB asked the Committee to identify three or four key actions that could be implemented immediately in order to increase Oregon’s ability to care for the newly insured in 2014. With 2014 now less than a year away, training any significant number of new primary care providers is out of the question. Consequently, the Committee’s revised recommendations focus instead on strategies for maximizing existing in-state workforce capacity, for recruiting already-trained professionals to Oregon and distributing them appropriately, and for increasing provider retention over the critical next few years. In addition, the Committee has included one analytic recommendation in this section: model future primary care workforce demand in the context of new delivery models. This modeling would not result in additional workforce capacity by 2014 but is included in the short-term recommendations

section because the analysis could be done this year and because the results would provide critical guidance for subsequent workforce development efforts.

In order of priority, the Committee's top recommendations for actions that can be taken now are:

1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible;
1. (Tie) Implement the new Medicaid loan repayment program for primary care providers
3. Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care; and
4. Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.

Additional detail for these recommendations can be found in Table 1, beginning on the following page. For each recommendation, the table specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim.

In addition to the four primary recommendations above, Committee members identified several other strategies that they believe would have a positive impact on primary care workforce capacity as soon as 2014. These strategies are also listed in Table 1.

Table 1: Short-term recommendations to increase primary care capacity in advance of 2014

What	When	Who*	Intended Impact & Relation to Triple Aim
<p>1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible. <i>(Category: Maximize existing capacity)</i></p>	2014	OHA CCOs Other payers	<p><i>Intended impact:</i> Widespread payment reform would accelerate adoption of new models of care (e.g. PCPCH) and allow practices to use the best, most efficient provider for a given need.</p> <p><i>Triple Aim:</i> Better care, lower costs</p>
<p>1. (Tie) Implement the new Medicaid state loan repayment program for eligible primary care providers. (CMS waiver requirement of \$2m annually for 13-15 biennium). <i>(Category: Recruitment)</i></p>	2013	Legislature OHA	<p><i>Intended impact:</i> 50-100 practitioners (depending on provider type mix and loan repayment amounts) obligated to serving Medicaid clients in rural and underserved areas.</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p>
<p>3. Forecast short and longer-term demand for primary care practitioners. <i>(Category: data)</i></p> <ul style="list-style-type: none"> ▪ Identify uninsured populations (demographic characteristics, geography, etc.) becoming eligible for coverage. ▪ Identify & summarize data on current levels of access to care ▪ Identify and summarize range of potential effects of new models of care/practice redesign on primary care capacity and make-up ▪ Model/forecast demand for primary care practitioners, using input data assembled earlier 	<p>June 2013</p> <p>June 2013</p> <p>June 2013</p> <p>October 2013</p>	OHWI and OHA - OHPR, with input from the Workforce Committee and other experts	<p><i>Intended impact:</i> Better, more nuanced projections of workforce demand and capacity will allow for more appropriately focused and scaled action to create the workforce that Oregon needs.</p> <p><i>Triple Aim:</i> An appropriately sized, skilled, and distributed health care workforce supports all three aspects of the Triple Aim.</p>
<p>4. Make better use of naturopaths as part of the primary care workforce: Remove contracting, credentialing, coverage, and payment barriers in CCOs and commercial carriers. <i>(Category: Maximize existing capacity)</i></p>	2013 and 2014	CCOs, health care facilities, commercial plans	<p><i>Intended impact:</i> Immediate increase in primary care workforce, achieved by capitalizing on an existing and in some cases under-utilized provider category.</p>

What	When	Who*	Intended Impact & Relation to Triple Aim
			<i>Triple Aim:</i> Better care via increased access for those interested in naturopathic care.
Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives. (<i>Category: Recruitment</i>)	2013 and 2014	OHA – PCO	<i>Intended impact:</i> Increased likelihood that communities, facilities, and providers will be eligible for other recruitment incentive programs (e.g. National Health Service Corps). <i>Triple Aim:</i> Better care and health via increased access for underserved groups.
Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a mechanism to keep providers near retirement in the workforce a few years longer and provide practice support for others. (<i>Category: Retention</i>) <ul style="list-style-type: none"> ▪ Add semi-retired physicians and mid-levels to pool of providers; expand scope of service to include after hours phone coverage for small and remote clinics. 	2014	Oregon AHEC	<i>Intended impact:</i> Improved physician retention/ reduced burnout due to relief services. Older physicians remain in practice longer by providing locum tenens service, increasing the flexibility of primary care workforce. <i>Triple Aim:</i> Better care via provider continuity; lower costs if the expense of new recruitment is avoided.
Make naturopaths eligible for the CMS waiver primary care loan repayment program. (<i>Category: Recruitment</i>)	July 2013	OHA in consultation/ negotiation with CMS	<i>Intended impact:</i> Expanded range of providers obligated to serving Medicaid clients in rural and underserved areas. <i>Triple Aim:</i> Better care via increased access for those interested in naturopathic care.
Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices. (<i>Category: Retention</i>)	2013	OHA Transformation Center; PCO, ORH, and OPCA, collaboratively; employers,	<i>Intended Impact:</i> Improved provider retention, reduced transition time for clinicians, practices, and patients. <i>Triple Aim:</i> Better care, potentially reduced costs due to reduction in recruiting services.

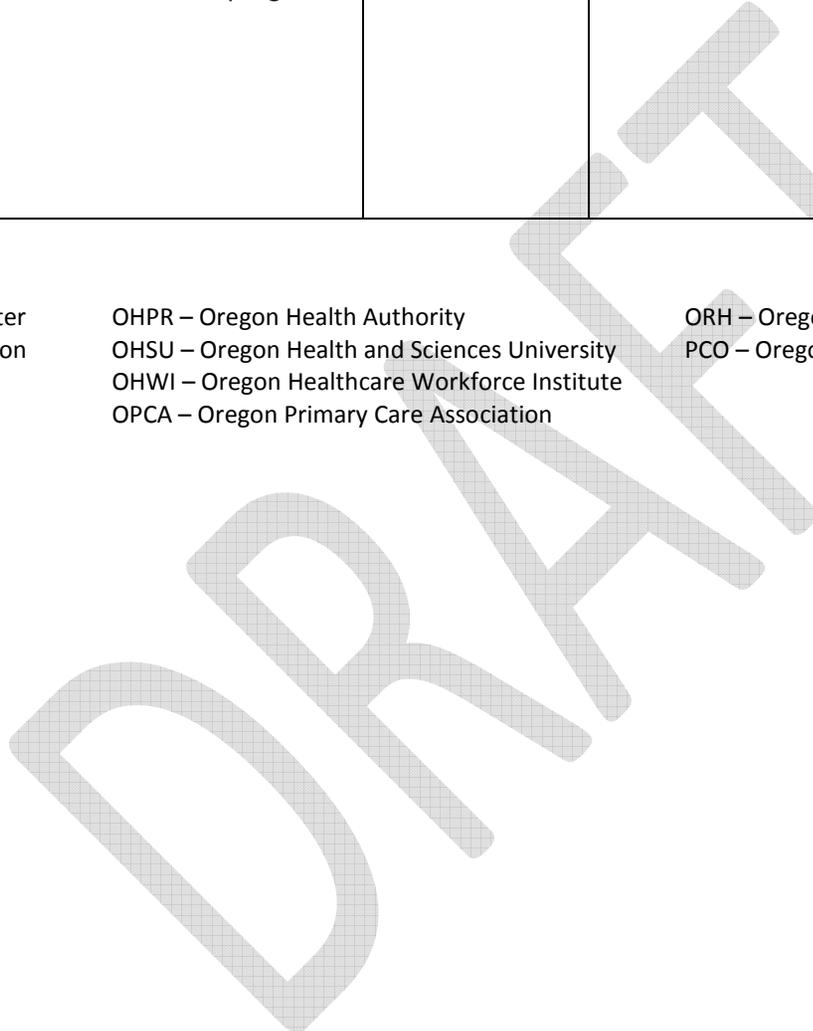
What	When	Who*	Intended Impact & Relation to Triple Aim
		practices, and communities	
Continue to do active outreach for J-1 visa waiver program	2013 and 2014	OHA – PCO	<p><i>Intended impact:</i> All available slots for foreign physicians to practice in underserved areas get filled</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p>

*Acronym list:

AHEC – Area Health Education Center
 CCO – Coordinated Care Organization
 ND – Naturopathic Doctor
 OHA – Oregon Health Authority

OHPR – Oregon Health Authority
 OHSU – Oregon Health and Sciences University
 OHWI – Oregon Healthcare Workforce Institute
 OPCA – Oregon Primary Care Association

ORH – Oregon Office of Rural Health
 PCO – Oregon Primary Care Office (within OHA)



Administrative and programmatic recommendations for 2014 and beyond

The OHPB's second request was for the Workforce Committee to identify key strategies for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation. In directing the Committee, Board members emphasized that these recommendations should be "reasonably achievable," even if some were more aspirational than others, and should focus on how workforce needs intersect with a transformed delivery model.

Because the request was for key strategies over a six- or seven-year time period, Workforce Committee members wished to make two cautionary points before offering recommendations:

- It is difficult to forecast future workforce needs when the model of care is changing rapidly and employers are not yet in consensus regarding the types of workers they want to hire. Educational institutions are reluctant to offer training when the likelihood of subsequent employment is not clear. To the extent possible, the Committee suggests framing conversations around the kinds of functions and competencies that providers will need to work within a transformed delivery model,¹ rather than around specific provider types.
- Workforce supply and demand are cyclical and vary by profession, geography, and other factors. For example:
 - Anticipating a looming nursing shortage, many educational institutions increased class sizes in the early and mid 2000s and graduated a much larger number of nurses than in the past. When the recession hit, many incumbent nurses delayed retirement, with the result that new associate and bachelors-degree nurses are reportedly having trouble finding jobs in the Willamette Valley and Portland metro area, but less so in other areas of the state. This situation may change once again as the economy improves and the demand for care increases in 2014.
 - The Committee has heard reports that dental hygienists and x-ray technologists are having difficulty finding employment in Oregon but that there is no shortage of employer demand for physicians, nurse practitioners, or physician assistants.

The Committee's top recommendations for programmatic and administrative action over the next several years span the categories of education, recruitment, retention, and workforce data and are:

1. Re-fund the state's Primary Care Loan Forgiveness Program;
2. Develop occupational training programs to respond to emerging care models and industry demand;

¹ See the Committee's January 2012 report to the Board, entitled Improving Oregon's Health: Recommendations for Building a Healthcare Workforce for New Systems of Care, at:

http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_WG1_12.27.11.pdf

3. (Tie) Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess;
3. (Tie) Enact workforce data reporting mandate for all health profession licensing boards;
4. Develop integrated health careers pathways, with central coordination; and
5. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

For each of these recommendations, Table 2 (following) specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim. Additional background information or context for several of the recommendations can be found in [Appendix A](#).

In addition to the six recommendations prioritized above, Committee members identified several other strategies that they believe would help develop Oregon's workforce in the right direction. These strategies are also listed in Table 2.

Table 2. Administrative and programmatic recommendations for 2014 and beyond

What	When	Who*	Intended Impact & Relation to Triple Aim
<p>1. Re-fund Oregon’s Primary Care Loan <i>Forgiveness</i> Program. (<i>Category: Recruitment</i>)</p> <p>Please see Appendix A for more information.</p>	July 2013	Legislature	<p><i>Intended impact:</i> Obligate 5-6 health professions students/year to rural practice in Oregon upon completion of training.</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p>
<p>2. Develop occupational training programs to respond to emerging care models and industry demand, e.g. Oregon Tech’s proposed new undergraduate major in Health and Human Behavior, or non-traditional health care worker training programs. (<i>Category: Education</i>)</p>	2014	Educational institutions, accrediting organizations, community-based organizations	<p><i>Intended Impact:</i> More Oregon students are prepared to deliver or access services in Coordinated Care Organizations or other new models.</p> <p><i>Triple Aim:</i> Better care and health via relevant training</p>
<p>3. (Tie) Ensure that CCOs’ required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess. (<i>Category: Data</i>)</p>	2013 and 2014	OHA Transformation Center, CCOs	<p><i>Intended impact:</i> Ensure that CCOs are considering workforce development in their comprehensive planning.</p> <p><i>Triple Aim:</i> Use workforce data to inform policies relevant to all three aspects of the Triple Aim</p>
<p>3. (Tie) Enact workforce data reporting mandate for all health professions boards. (<i>Category: Data</i>)</p> <p>Please see Appendix A for more information.</p>	2014	Legislature; licensing boards	<p><i>Intended impact:</i> Create a more complete dataset on the characteristics and practices of Oregon’s licensed healthcare workforce.</p> <p><i>Triple Aim:</i> Use data to inform policies relevant to all three aspects of the Triple Aim</p>
<p>5. Develop integrated health careers pathways, with central coordination. (<i>Category: education</i>)</p> <p>Please see Appendix A for more information.</p>	2014	Oregon AHEC, CC’s, CCWD, OUS, private universities	<p><i>Intended Impact:</i> More Oregon students enter health professions training because the pathway from elementary through professional training is easier to navigate and coordinated statewide, and appropriate resources are available to students at all levels.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p>

What	When	Who*	Intended Impact & Relation to Triple Aim
<p>6. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information. <i>(Category: education)</i></p> <p>Please see Appendix A for more information.</p>	Beginning of 2014-15 academic year	OHA for admin. rules; Consortium collaboration among schools and clinical sites for tracking system, with input from Workforce Committee	<p><i>Intended Impact:</i> Reduce inefficiencies and costs for student clinical placements to increase capacity.</p> <p><i>Triple Aim:</i> Improve quality & decrease costs of educational experience; better care via positive adjustments to workforce capacity</p>
<p>Revise state’s Adverse Impact law and related regulations. <i>(Category: Education)</i></p> <p>Please see Appendix A for more information.</p>	2013	Higher Education Coordinating Council	<p><i>Intended Impact:</i> A level field exists for program approval between public, private and proprietary institutions, making it easier to “right-size” programs.</p> <p><i>Triple Aim:</i> Improve quality of education experience; better care via positive adjustments to workforce capacity</p>
<p>Maximize opportunities for license reciprocity. <i>(Category: Recruitment)</i></p> <ul style="list-style-type: none"> ▪ Identify licensing boards’ current efforts allowing for reciprocity or expedited licensure for professionals already licensed in other states. ▪ Identify challenges (e.g. laws, regulations) that hinder opportunities for reciprocity. 	2013	Healthcare Workforce Committee; Licensing Boards	<p><i>Intended impact:</i> Fewer barriers to recruiting professionals licensed in other states resulting in an increased supply of professionals for Oregon.</p> <p><i>Triple Aim:</i> Better health and care via increased access.</p>
<p>Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners. <i>(Category: Recruitment/Retention)</i></p>	2013	All health professional training programs	<p><i>Intended impact:</i> More professionals are better prepared for practice in rural Oregon.</p> <p><i>Triple Aim:</i> Better care</p>
<p>Adopt a uniform credentialing system statewide, in</p>	2014	Health Leadership	<p><i>Intended impact:</i> Fewer barriers to provider affiliation</p>

What	When	Who*	Intended Impact & Relation to Triple Aim
alignment with Health Leadership Council work. (Category: Recruitment/Retention)		Council; health plans; health systems; OHA	with plans and hospitals <i>Triple Aim:</i> Reduced costs via administrative simplification
Develop a system for creating “workforce impact statements, i.e., statements of workforce needs generated by implementation of reform proposals. (Category: Data)	2014	OHWI	<i>Intended impact:</i> Build evidence on workforce implications of health care transformation to inform training t and refine projections of future workforce demand. <i>Triple Aim:</i> Use data to inform policies relevant to all three aspects of the Triple Aim

*Acronym list:

AHEC – Area Health Education Center
 CCO – Coordinated Care Organization
 ND – Naturopathic Doctor
 OHA – Oregon Health Authority

OHPR – Oregon Health Authority
 OHSU – Oregon Health and Science University
 OHWI – Oregon Healthcare Workforce Institute
 OPCA – Oregon Primary Care Association

ORH – Oregon Office of Rural Health
 PCO – Oregon Primary Care Office (within OHA)

Additional recommendations for increasing primary care workforce capacity

Finally, the Workforce Committee offers two additional recommendations for action after 2014. These are presented separately in Table 3 because they do not fit in the category of “programmatic and administrative” recommendations. The two recommendations are:

1. Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually.
2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Some knowledge of the structure and funding of graduate medical education (GME) in the U.S. is necessary to fully judge these recommendations; that background is provided in Appendix A.

DRAFT

Table 3. Additional recommendations for increasing primary care workforce capacity

What	When	Who *	Intended Impact & Relation to Triple Aim
<p>1. Increase number of Family Medicine residencies by at least 3 residencies with at least 24 new positions annually. (Oregon ranks 39th in primary care residents/100,000 population at 8.2/100K; US average is 13/100K). (<i>Category: Education</i>)</p> <p>Please see Appendix A for more information.</p>	2016	Health systems, Dept. of Family Medicine, OHSU	<p><i>Intended impact:</i> Oregon meets the US average for primary care residents per 100,000. An increased number of physicians are trained locally, increasing the pool from which to recruit.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p>
<p>2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty. (<i>Category: Education</i>)</p> <p>Please see Appendix A for more information.</p>	2017	Health systems, OHSU	<p><i>Intended impact:</i> An increased number of physicians are trained locally, increasing the pool from which to recruit.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p>

*Acronym list:

AHEC – Area Health Education Center
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 ND – Naturopathic Doctor
 OHA – Oregon Health Authority

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 OHSU – Oregon Health and Science University
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 OPCA – Oregon Primary Care Association

ORH – Oregon Office of Rural Health
 PCO – Oregon Primary Care Office (within OHA)

Appendix A – Additional Detail for Selected Recommendations

Some of the recommendations in Table 2 and 3 need more context and rationale than is possible to present in table format. Additional detail for those recommendations is provided here.

From Table 2

Recommendation: Re-fund Oregon’s Primary Care Loan *Forgiveness* Program

Background: Oregon’s primary care loan forgiveness program was created and funded for two years in 2011. It provides 6-8 loans annually to students enrolled in Oregon programs specifically designed to prepare providers for practice in a rural setting. For each year that loans are received, participants agree to practice in a rural setting in Oregon, following their graduate and residency training. Students of medicine, nursing, or physician assisting (a.k.a. “prospective” primary care practitioners) who have completed at least one year of education are eligible. Loan forgiveness differs from loan repayment in that it targets health professions students early in their education, perhaps helping to influence selection of primary care over another specialty. HB 2858, currently under consideration in the 2013 legislative session, would appropriate \$1 M for the primary care loan forgiveness program for the 2013-15 biennium.

Recommendation: Enact a workforce data reporting mandate for all health professions licensing boards

Background: The same legislation that created the Health Policy Board and the Oregon Health Authority also directed the Authority to collaborate with 7 health professional licensing boards to collect demographic and practice information from licensed healthcare professionals at the time of license renewal. The 7 Boards were: Oregon Board of Dentistry; Oregon Board of Pharmacy; Oregon Health Licensing Agency for the Oregon Board of Licensed Dietitians; Oregon Medical Board; Oregon Occupational Therapy Licensing Board; Oregon Physical Therapist Licensing Board; and Oregon State Board of Nursing. These boards support database operations via a small per-licensee fee and the overall response rate is very high, since the legislation specifies that the Boards may not renew a license until the workforce information has been collected. Starting in 2012, three additional boards—the Board of Licensed Clinical Social Workers, the Board of Psychologist Examiners, and the Board of Licensed Professional Counselors and Therapists—began to ask their licensees to provide data on a voluntary basis. There are more than 10 other healthcare professional licensing boards that do not currently participate.

To enable collection and analysis of accurate and comparable data for all licensed health care providers in the state, the Workforce Committee recommends that required participation in the Healthcare Workforce Database be extended to all health professional licensing boards in 2014, with actual reporting to be phased in according to data priorities and board readiness. This is a repeat recommendation from the Workforce Committee.

Recommendation: Develop integrated health careers pathways, with central coordination

Background: The Committee made this recommendation at the end of 2012 and noted that it would connect two of the Governor’s priorities: healthcare reform and education reform. The overarching recommendation was that Oregon should develop a coherent pipeline to health careers at all levels, beginning with elementary education. The pipeline should organize and connect students to activities and programs that progressively build on student knowledge and experience, and effectively utilize state resources and investments in education from K-12 through higher education and health professional education. Sufficient resources should be available to meet statewide need. More specifically, the Committee recommends:

- Explicitly including health sciences in the “science” category of Oregon’s Science, Technology, Engineering and Mathematics (STEM) initiative, since preparation for the health professions requires competency in the same base disciplines.
- Aligning state health care professional education investments with projected Oregon workforce needs, as identified by the Workforce Committee, the Oregon Healthcare Workforce Institute, and others. Data regarding the predicted demand for health professionals should drive education program development and distribution.
- Providing additional funding and support for the development and distribution of health care occupations training to rural communities and underrepresented populations across the K-20 pipeline and increasing incentives to reach diversity goals for the health professional pipeline.
- Encouraging the use of up-to-date delivery modalities, including virtual learning, to increase access to health professions education throughout the state. Distance or distributed learning can help maximize finite resources by aggregating the demand for training but distributing the supply.
- Encouraging inter-institutional cooperation and integration of curricula. All health care professions education should address new models of care in a

consistent way, emphasizing the competencies needed for interprofessional team-based care.

Recommendation: Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

Background: In July 2012, the Health Policy Board approved a set of standard prerequisites for student clinical placement that were developed by the Workforce Committee in consultation with a broad range of stakeholders.² Committee members are currently working with the Health Authority and a rules advisory committee to develop administrative rules to implement and enforce the standards.

When approving the standards, the Board strongly advised the Committee and stakeholders to develop a centralized method of tracking students and their prerequisites across clinical placement sites. Committee members are considering options for a centralized system and OHA has issued an RFI to gather more information on the Committee's behalf. Determining the best structure and most appropriate functions of a centralized tracking system is doable; the more challenging implementation task is to determine how such a system might be governed and financed. Stakeholders have stated clearly that they would prefer the state not to administer such a system; for this reason, a not-yet-existing consortium/coalition of schools and clinical placements sites was identified as the responsible party for this part of the recommendation in Table 2.

Recommendation: Revise Oregon's adverse impact laws and regulation

Background: Oregon has a unique policy that requires community colleges to submit a notice of intent at least 30 days prior to seeking Board of Education approval for certain new programs. The Board must then share this notice with private institutions. Private institution officials who feel that the new public program would adversely impact their businesses may file an objection, which sets in motion a proscribed process of negotiation. Notably, the reverse is not true: private institutions are under no obligation to provide notice about planned new programs and publicly-funded programs have no formal opportunity to express objections. The policy can have the effect of delaying or limiting the creation of needed training programs, overwhelming clinical placement sites, or increasing students' costs (because private programs tend to be more expensive for students).

² See: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_SB879_06.29.12.pdf

In 2011 and 2012, members of the Workforce Committee met several times with staff from the Office of Degree Authorization and representatives from public, private, and proprietary schools. At the end of this process, the Committee recommended a small change to statute and administrative rule that would have the effect of requiring *all* institutions—public, private and proprietary—to notify others of proposed new programs and be subject to review for detrimental duplication or adverse impact. A letter recommending this regulatory change was sent to the Higher Education Coordinating Commission, in August 2012. No response has been received to date; however, the 2013 Legislature is considering a bill (HB 3341) that would make some changes to the adverse impact policy and has heard testimony about the Workforce Committee’s recommendation.

From Table 3

Recommendations: Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually; and increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Background: Upon completion of medical school, all new graduates pursue a “residency” in Graduate Medical Education (GME) in a specialty of their choice (the first year of training is sometimes called “internship”). Oregon currently supports more than 800 GME positions in all specialties. Residencies last from three years to more than 5 years. About 275 new positions open up each year. 776 total positions are at OHSU. Providence Health System hosts programs in Family Medicine (7 new positions per year), and Internal Medicine (17 positions per year). The Legacy Health System hosts 15 new Internal Medicine residents per year. In addition, Samaritan Health Services offers 20 first year residency positions, currently open only to DO students, in their Corvallis based residencies in Family Medicine(5), Internal Medicine (6), General Surgery (2), Orthopedic surgery (3), and Psychiatry (4). Residency positions are open on a competitive basis to MD and DO students from all around the US and the world. These training opportunities at OHSU are highly sought after and, through a program called the National Residency Matching Program, students from around the country are “matched” to these residency positions. Each year, some, but not the majority, of the students who become residents are from Oregon.

Studies show a strong correlation between where a new physician completes GME training and where s/he ends up practicing. Expanding GME capacity in Oregon in areas where physicians are most needed could have an immediate and ongoing impact on reversing workforce shortages. OHSU is ranked tenth in the nation for

in-state retention of physicians after GME training, with 52% of residents staying in Oregon to practice. However, only one-third of all licensed Oregon physicians completed all or part of their training in Oregon, making Oregon a longstanding importer of physician workforce.

The federal Medicare dollars that help pay for training of new physicians in teaching hospitals around the country are essential to funding GME programs. However, in 1997 as part of the Balanced Budget Act, the federal government froze the number of GME positions it would support for hospitals *participating at that time*. This is often referred to as the federal “cap” on residents/trainees. However, hospitals that do not yet have an existing GME training program remain eligible to receive federal funding for establishing new programs. Thus, new federal dollars could be available to Oregon hospitals to help support new GME training sites.

The federal dollars that help pay for training of new physicians in teaching hospitals around the country are essential to this advanced training/GME program. However, in 1997 as part of the Balanced Budget Act, the federal government froze the number of GME positions it would support for hospitals *participating at that time*. This is often referred to as the federal “cap” on residents/trainees. However, hospitals that do not yet have an existing GME training program remain eligible to receive federal funding for establishing new programs. Thus, new federal dollars could be available to Oregon hospitals to help support new GME training sites in Oregon.

To qualify, these positions must gain accreditation by the Accreditation Council for Graduate Medical Education and/or the American Osteopathic Association— a multi-year process that involves development of peer-reviewed curriculum that includes an adequate numbers of patients and procedures to gain expertise in the program specialty. GME training in many specialties and sub-specialties requires the programs to be located in large population centers in order to see a sufficient volume of specialty patients. Primary care residencies, especially Family Medicine, are, however, well suited to smaller communities outside the Portland Metro area.

Several smaller Oregon communities have indicated their interest in exploring the option of having GME at their medical centers, such as Salem, Roseburg, Grants Pass, Eugene, Medford, Hood River, and Bend. Currently, the only rurally-based training program in Oregon is the Cascades East Family Medicine Residency Program in Klamath Falls, with 8 new positions per year.

Because the GME programs at community hospitals are necessarily small (typically 2-8 residents per year in each specialty), a GME Consortium approach could support regional programs with common curriculum design, an accreditation umbrella and other program and administrative requirements. This will ensure that hospitals and other community-based sites have a centralized framework for cooperation so Oregon is allotted the maximum number of federally-funded positions and, equally important, that these positions are nationally competitive to attract the highest caliber new physicians to Oregon.

Oregon currently has only one rural Family Medicine training location, *OHSU Cascades East Program in Family Medicine*. Cascades East Family Medicine supports 24 trainees (8 new positions per year) in a three-year program. Started in 1993 at Sky Lakes Medical Center in Klamath Falls, Cascades East Family Medicine Residency is also supported by OHSU Family Medicine Department and Oregon AHEC and has achieved great success. More than 75% of its graduates practice in towns less than 25,000, with many in the smallest communities in Oregon. Providence Family Medicine Residency is in the final stages of adding an additional Rural Training Track position for one resident who will spend the final 2 years of residency in Hood River.

GME programs can become self-sustaining in their 3rd year when federal support becomes available. Startup costs are needed to support administration, faculty, curriculum development and organization, accreditation and related issues. A common structure to help administer established residency programs after the startup phase is complete would also help reduce costs and improve quality.

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From: Sarah Baessler [baessler@oregonrn.org]
Sent: Monday, March 18, 2013 5:43 PM
To: lisa.angus@state.or.us
Subject: Workforce Committee Primary Care Recommendations

Hi Lisa,

Thanks for taking my call on Friday.

I wanted to follow up on our conversation about the Health Care Workforce Committee Recommendations regarding primary care workforce.

ONA is pleased to see the committee focusing on primary care and looks forward to partnering with this committee and others to ensure we have a robust primary care workforce ready to meet the health care needs of our population, especially in this time of health care reform.

That being said, the issue of license reciprocity is one that is a bit concerning to ONA. Currently, the Oregon State Board of Nursing (OSBN) has an "endorsement" process, by which a nurse who is currently or formerly licensed in good standing in another state, **and** meets Oregon's education, practice, and legal requirements for nursing licensure can go through a process with OSBN to obtain licensure by endorsement.

This process, as opposed to reciprocity, ensures that nurses licensed and practicing in Oregon meet Oregon's standards. This is particularly an issue for Oregon's Nurse Practitioners, who have earned a broad scope of practice including the authority to practice without supervision, and to prescribe and dispense medication. OSBN education requirements for Nurse Practitioners reflect this, where a Nurse Practitioner practicing in a state without independent practice or prescriptive authority may have much different requirement.

On a separate note, the Enhanced Primary Care Medicaid Payments that were part of the Affordable Care Act excluded independent nurse practitioners from participating, despite the fact that many of these NPs treat Medicaid patients. Dr. Goldberg and members of Oregon's Congressional Delegation have asked CMS for some flexibility in implementing this program. While the final rules were pretty clear about independent NPs being excluded, certainly including them could have an impact on Oregon's Primary Care workforce.

Thanks so much for the opportunity to submit this feedback.

Best,

Sarah

Sarah Baessler

Director of Health Policy and Government Relations
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From: Downey, Kristen J [Kristen.Downey@providence.org]
Sent: Monday, March 25, 2013 3:37 PM
To: 'lisa.angus@state.or.us'
Cc: Rodriguez, Glenn MD; Simmons, Adrienne
Subject: Health Care Workforce Committee: March 19 GME discussion

Categories: Follow-up

Dear Lisa,

Providence Health & Services extends our appreciation to the Health Care Workforce Committee for tackling such complex issues. Given that the March 19 meeting was not open for public comment, I would like to take this opportunity to provide some clarity around Providence's Graduate Medical Education program on behalf of our Chief Executive of Medical Education, Glenn Rodriguez, M.D.

At Providence we take our commitment to GME training very seriously and are proud of our contribution to the statewide program, in partnership with Oregon Health Sciences University. The following addresses comments made by committee members:

- Providence directly sponsored residency programs are all in primary care, one family medicine program and two internal medicine programs.
- The family medicine program lasts three years.
 - Currently we have a total of 21 residents, seven spots per year.
 - Beginning in July 2013 Providence will have a rural residency track in Hood River and will add an additional resident. By 2015 this program could increase our total number of family medicine residents to 24.
- The internal medicine program also lasts three years.
 - Providence St. Vincent has a total of 27 residents each year - eight spots in the full program per year and three transitional, or one year, slots.
 - Providence Portland Medical Center has a total of 30 residents each year - nine spots in the full program per year and three transitional slots.
- Providence has been paying salary and overhead costs for OHSU residents as follows: OB/GYN (1.5 FTE per year), surgery (8.7 FTE per year) and emergency medicine (4.15 FTE per year).
- Federal funding for GME, which flows through the Medicare and Medicaid programs, establishes a CMS cap on funded positions. Providence currently funds 14.35 FTE salary positions above our federal cap.

From our perspective it is important that other Oregon institutions consider implementing GME programs to support the state. Valuable short-term solutions may include the use of Medicaid GME funding for primary care, psychiatry and surgery programs; support for the development of rural track training programs; and support for community based training programs, such as in Federally Qualified Health Clinics.

We thank you for your continued work. Please don't hesitate to contact me or Dr. Rodriguez (Glenn.Rodriguez@providence.org) with questions.

Sincerely,
Kristen Downey
Regulatory Services Analyst - Oregon

Work: 503-893-6368
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Implementation of the ACA: Individual & Small Group Markets

Oregon Health Policy Board

April 2, 2013

*Barney Speight, Special Advisor
Oregon Health Authority & Governor's Office*



Outline of Presentation

- Background on Current Individual Market
- ACA Reforms in Individual Market
- Implications & Mitigation Initiatives
- Proposed Legislation
- ACA Reforms in Small Group Market

Current Individual Market ₁



- Medical Underwriting
 - Accept or Reject
- Covered Services Can Vary
 - Mental Health
 - Prescriptions
- Wide Choice of Cost Sharing Options
 - Deductibles, Co-Insurance, Out-of-Pocket Max.



Current Individual Market 2

- ~ 10% of Private Health Insurance Market
- Competitive Marketplace
 - 7 domestic carriers insure 85% of the market
 - HealthNet, Kaiser, Lifewise, ODS, PacificSource, Providence, Regence

Medical Underwriting Rejections



2012 Quarter	Applications Received	Applications Rejected
1 st	20,065	4,263
2 nd	18,676	4,042
3 rd	20,539	4,270
4 th	20,816	4,307
Total	80,096	16,882

21%

Source: DCBS Quarterly Health Insurance Reports, 2012

Oregon Medical Insurance Pool (OMIP)



- 11,120 members (Jan., 2013)
- 69% > age 45; 59% female; 61% < \$45,000
- 3 medical plans (750 / 1,000 / 1,500); one TPA
- Loss ratio ~ 199%
 - Policy Expenses/Month = \$1,434
 - Policy Premium/Month = \$605
- 2012 Assessments = \$89.3 million (\$5.09 pmpm)



ACA Reforms in Individual (Non-Group) Market



Access to Coverage

- Guaranteed issue & renewability
 - Elimination of medical underwriting
- Requirement to have insurance (“individual mandate”) with exceptions & penalties

Essential Health Benefits (EHB)



- Ten (10) Coverage Categories
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity & newborn care
 - Mental health & substance use disorder
 - Prescription drugs
 - Rehabilitative & habilitative services/devices
 - Preventive/wellness services & chronic disease management
 - Pediatric services, including vision & dental

Standardized Levels of Coverage



- Bronze: Covers 60% of expected costs for the average individual
- Silver: Covers 70% of expected costs...
- Gold: Covers 80% of expected costs...
- Platinum: Covers 90% of expected costs...

SB 91 Standard Plans (Bronze & Silver) required both inside and outside the Exchange

Maximum Cost Sharing Standards



- Maximum annual out-of-pocket cost sharing in 2014:
approximately \$6,500 / \$13,000
 - Deductibles, co-pays & coinsurance



Rating Reforms

- Single Risk Pool
 - Plans offered inside & outside Exchange
- Modified Community Rating
 - Premiums adjusted for:
 - Family size
 - Geography
 - Age (with variation no greater than 3:1 for adults between 21 & 64)
 - Tobacco use (up to 1.5)



Catastrophic Plan

- Available to persons < 30 & those exempt from mandate due to financial hardship
- Design
 - Covers Essential Health Benefits
 - Deductible of approximately \$6,500, then 100% coverage
 - At least 3 primary care visits/year before deductible
 - No cost sharing for specified preventive health services

Financial Assistance with Costs of Coverage



- Refundable, advanceable premium credits to persons between 100% – 400% FPL for coverage purchased in the Exchange
- Cost-sharing subsidies for persons under 250% FPL
- An estimated 23% decrease in individual market member out-of-pocket costs (premiums + cost sharing)

How Premium Tax Credits Work



- 1. Cost of aged-adjusted, 2nd lowest-cost Silver Exchange Plan (“Silver Reference Plan”)
- 2. Minus Maximum Monthly Premium Contribution (sliding scale based on income)
- 3. Equals refundable and advanceable premium tax credit paid to carrier by Treasury
- Individual can choose any plan, but will pay more for plans with premiums higher than “Silver Reference Plan”



Maximum Monthly Premium Contributions, by Family Size...

Federal Poverty Level (FPL)	Maximum Premium as % of Income	Family of 1	Family of 2	Family of 3	Family of 4
133%	2.0%	\$24	\$33	\$41	\$50
150%	4.0%	\$54	\$74	\$93	\$112
200%	6.3%	\$114	\$154	\$195	\$235
250%	8.05%	\$183	\$247	\$311	\$375
300%	9.5%	\$259	\$349	\$440	\$531
350%	9.5%	\$302	\$408	\$513	\$619
400%	9.5%	\$345	\$466	\$587	\$708

If Premium Credits were Available in 2011. Congressional Research Service, June 13, 2012, 7-5700

Example



Family of 1, 250% FPL	
Silver Reference Plan	\$ 400.00
Maximum Premium Contribution	- 183.00
Tax Credit	217.00
Total Paid by Individual	\$ 183.00

Family of 1, 250% FPL	
Alternative Silver Plan	\$ 435.00
Tax Credit	- 217.00
Total Paid by Individual	\$ 218.00

Those Exempt from Individual Mandate



- Religious belief
- Undocumented immigrant
- Incarcerated
- Member of an Indian tribe
- Family income < threshold for filing taxes
- Have to pay more than 8% of income for health insurance (after employer contributions or tax credits)

Coverage that Satisfies Mandate



- Medicare
- Medicaid, CHIP
- TRICARE (service members, retirees, families)
- Veteran's health program
- Employer sponsored insurance
- Self purchased (if at least at Bronze AV level)
- Grandfathered plan

Penalties for Not Having Health Insurance



- 2014
 - The greater of: \$95/adult and \$47.40/child (up to \$285 for a family) or 1.0% of family income
- 2015
 - The greater of: \$325/adult and \$162.50/child (up to \$975 for a family) or 2.0% of family income
- 2016
 - The greater of: \$695/adult and \$347.50/child (up to \$2,085 for a family) or 2.5% of family income

After 2016, penalties increased by cost of living.



Implications & Mitigation Initiatives

Cost Factors Associated with ACA



Table 2: Individual Market Premium Impacts under ACA (2014 compared to 2011)

ACA Requirement	Average Premium Impact		
	Low	Best Estimate	High
Essential Benefits Requirement	5%	6%	7%
Bronze Minimum Act. Value (includes Max OOP limit)	1%	2%	3%
Minimum Loss Ratio = 80%	-2%	-1%	0%
Morbidity Change (due to new insured/uninsured)	10%	15%	25%
Age Slope Limited to 3:1	0%	0%	0%
Provider Fee	1%	1%	1%
Reinsurance Program	-9%	-8%	-7%
Elimination of OMIP Assessment	-2%	-1%	0%
Subtotal (ACA Requirements)	2%	13%	30%
Individual Submarket Merger	24%	22%	20%
Total Premium Impact	27%	38%	55%

Impact of Premium Credits

Table 19: Effective Premium Tax Credit by Income Level

FPL	Individual Premium Impacts		# of Members		% Eligible for Tax Credits	
	Before Premium Tax Credits	After Premium Tax Credits	Currently Insured	Newly Enrolled	Currently Insured	Newly Enrolled
133-150%	23%	-50%	12,639	8,162	100%	100%
151-200%	24%	-37%	29,181	18,844	100%	100%
201-250%	27%	-16%	30,079	19,424	91%	95%
251-300%	25%	0%	17,524	11,316	67%	53%
301-350%	22%	8%	8,741	5,645	53%	40%
351-399%	34%	29%	6,080	3,927	51%	36%
400%+	20%	20%	72,747	6,613	0%	0%
Total	24%	-10%	176,991	73,929	50%	74%



Mitigation Programs

- Re-Insurance
 - Federal program
 - 3 years: 2014, 2015, 2016
- Risk Corridors
 - Federal program
 - 3 years: 2014, 2015, 2016
- Risk Adjustment
 - Federal program (with State option)
 - Permanent



Federal Re-Insurance

- Federal Re-Insurance Program
 - Stop Loss protection for carriers against financial losses from members with unusually high claims.
 - Funded by assessment on all insured and self-insured group plans (est. \$5.25 pmpm)
 - 2014 impact on premiums estimated at – 11.00%



Federal Risk Corridors Program

- Used to mitigate pricing risk when data on health spending for potential enrollees is limited.
- Redistributes funds from QHPs with large profits to those with large losses
 - Target range from 97% to 103%
 - Those who pay to HHS are below 97% of target
 - Those who are paid by HHS are above 103%



Risk Adjustment Program

- Permanent program operated by HHS or by State
 - Oregon will utilize the federal program
- Redistributes premiums across health plans to account for the relative risk of plan participants
 - Plans that enroll members with higher than average health needs will see positive (+) premium adjustments
 - Plans that enroll members with lower than average health needs will see negative (-) premium adjustments.



Table 1
Program Applicability by Market and Administration

ACA Provision	Sold within Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grandfathered	State Run Exchange	Federal Run Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS ¹	HHS
Reinsurance (Payments) ³	Yes	No	Yes	No	No	State or HHS ¹	State or HHS ¹
Risk Corridor	Yes	Yes	No ²	No ²	No	HHS	HHS

¹State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

²Risk Corridors will apply to QHPs offered outside of the Exchange if they are substantially similar to a QHP offered inside the Exchange.

³All markets contribute to reinsurance, but the payments only apply to the individual market.



Proposed Legislation Relating to ACA Implementation in Commercial Markets

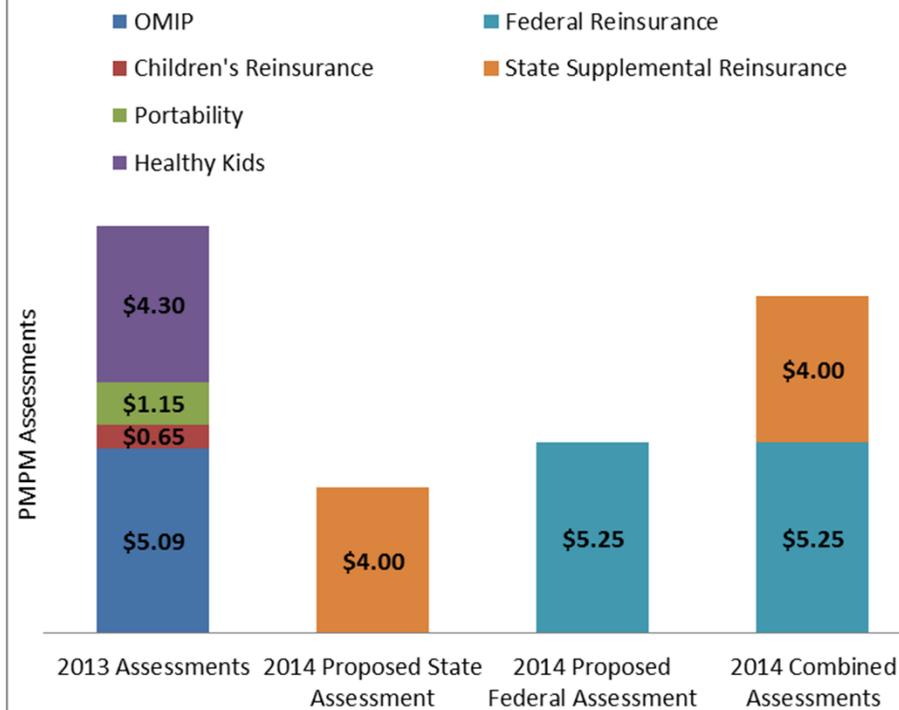
State Re-Insurance Program (LC 3718)



- Would provide additional Stop Loss protection for high claims costs associated with persons moving from OMIP, FMIP, Children's Re-Insurance & Portability plans
- Would be funded by assessment similar to current OMIP program (which is ending)
 - Reduced PMPM from current level
 - Declining over 3 years
 - Sunsets after 3 years
- 2014 impact on premiums estimated at -4.00%



Comparison of 2013 and 2014 High-Risk Pool Assessments Fully Insured





HB 2240

- Amends Oregon Insurance Code to align with federal requirements under ACA
- Provides DCBS with authority to make administrative rule changes that reflect guidance & regulations from federal agencies relating to ACA implementation
- Phases out Office of Private Health Partnerships (OPHP) & Family Health Insurance Assistance Program (FHIAP). Members will transition to Cover Oregon or Oregon Health Plan



ACA Reforms in Small Group Market



Small Group Market

- 2014: Groups under 50 employees
- 2016: Groups under 100 employees
- 2017: Exchange available to groups over 100 employees with State legislative approval
- Purchasing through the Exchange is optional for small business
 - Must buy through the Exchange to receive tax credits



New Requirements

- Essential Health Benefits
- Minimum Actuarial Value (AV)
 - Bronze (60% AV), Silver, Gold, Platinum
- Prohibition of annual limits
- Limits on cost-sharing
 - Maximum annual deductible of \$2,000/\$4,000
- Rating Rules
 - Adjusted Community Rating (3:1)
 - Elimination of underwriting factors

Table 4: Changes to Small Group Market Premiums under ACA (2014 compared to 2011)

ACA Requirement	Average Premium Impact			Range of Group Impact	
	Low	Best Estimate	High	Low	High
Compliance with MOOP, deductible	0%	0%	0%	Varies	Varies
Essential Benefits Requirement	1%	2%	3%	1%	3%
Bronze Minimum Act. Value	0%	0%	1%	0%	6%
Removal of OMIP and Portability Assessment	-3%	-2%	-1%	-3%	-1%
Minimum Loss Ratio = 80%	0%	0%	0%	-6%	0%
Age / Gender Slope ^{1,5}	0%	0%	0%	-10%	50%
U/W - Participation ^{1,2}	0%	0%	0%	-14%	8%
U/W - Contribution ^{1,3}	0%	0%	0%	-7%	4%
U/W - Health Status ⁴	0%	1%	3%	-5%	5%
Morbidity Change	-5%	0%	5%	N/A	N/A
Provider Fee	0%	1%	1%	0%	1%
Reinsurance Assessment	1%	1%	1%	1%	1%
Subtotal (ACA Requirements)	-5%	3%	14%	-37%	95%
Submarket Merger	0%	1%	2%	0%	2%
Total	-5%	4%	16%	-37%	99%



Traditional Choice

	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$400	\$395	\$450	\$420
Gold	\$375	\$375	\$400	\$380
Silver	\$350	\$330	\$380	\$340
Bronze	\$325	\$300	\$340	\$320

Carrier Choice

	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$400	\$395	\$450	\$420
Gold	\$375	\$375	\$400	\$380
Silver	\$350	\$330	\$380	\$340
Bronze	\$325	\$300	\$340	\$320

Metal Tier Choice

	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$400	\$395	\$450	\$420
Gold	\$375	\$375	\$400	\$380
Silver	\$350	\$330	\$380	\$340
Bronze	\$325	\$300	\$340	\$320

Broad Choice

	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	\$400	\$395	\$450	\$420
Gold	\$375	\$375	\$400	\$380
Silver	\$350	\$330	\$380	\$340
Bronze	\$325	\$300	\$340	\$320

Oregon's Strategic Approach



- Makes sure companies are solvent and can pay claims
- Licenses agents
- Reviews policies/rates
- Staffs consumer hotline
- Helps with insurance complaints/appeals
- Enforces federal and state insurance laws



- Oversees health reform
- Administers Medicaid programs (OHP)
- Approves coordinated care organizations for OHP members
- Manages public health and addictions and mental health
- Oversees public employee benefits



- Online shopping for individuals, small employers, and Medicaid
- Links to tax credits to make insurance affordable
- Help finding the right coverage through navigators/agents



For Follow – Up:

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Oregon
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Potential Impact of Federal Sequestration – Public Health Division

The following are initial estimates of the reductions that *could* take place in OHA's Public Health Division due to federal sequestration. The reductions would take place mostly during the 2013-2015 biennium, however reductions in some services could occur during the remainder of this biennium:

Public Health Emergency Preparedness:	\$1.2 million*
Drinking Water Services:	\$1.4 million*
Women and Children (WIC)	\$7.5 million*
MCH Block Grant	\$950,000*
HIV testing	\$350,000*
Family Planning Services	\$450,000*
Breast and cervical cancer screening	\$350,000*
Total	\$12.2 million*

****Initial estimates***

Public Health Emergency Preparedness – A reduction of \$1.2M would reduce Oregon's ability to effectively respond to and recover from biological, radiological, chemical and natural disasters.

Drinking Water Services – Early information indicates an EPA reduction of an estimated \$1.4M which would reduce the ability to perform inspections of drinking water systems and assure safe drinking water to Oregonians.

WIC – A reduction of \$7.5M would result in 7,600 fewer Oregon mothers and young children receiving food and nutrition services.

MCH Block Grant – A reduction of \$950K would result in up to 256,239 fewer women, children and families being served.

HIV testing – A loss of \$354K would mean 2,800 fewer Oregonians will be tested for HIV.

Family Planning Services - A reduction of \$460K would reduce access to reproductive health services, and lead to an increase in unintended pregnancies.

Breast and cervical cancer screening – A loss of \$340K would mean an estimated 676 fewer Oregon women would be screened for breast and cervical cancer.

Potential Impact of Federal Sequestration – OHA Addictions and Mental Health

The following are initial estimates of the reductions that *could* take place in OHA’s Addictions and Mental Health Division due to federal sequestration. The reductions would take place during the 2013-2015 biennium:

Substance Abuse Prevention and Treatment (SAPT) Block Grant	\$900,000 reduction*
Mental Health Block Grant	\$400,000 reduction*
Total:	\$1.3 million*

****Initial estimates***

The Substance Abuse Prevention & Treatment (SAPT) Block Grant funds addiction and recovery services, critical components of a comprehensive health care system that seeks to contain costs and improve overall health in Oregon. The block grant primarily pays for out-patient and residential substance abuse treatment for people who are not eligible for Medicaid or for treatment services that are not covered by Medicaid, such as peer-delivered services. Sequestration will cut \$890,000 from Oregon’s SAPT block grant.

Most of the impact will be on future enrollments, not on people who are currently receiving treatment. The Oregon Health Authority (OHA) estimates that about 590 fewer Oregonians will be enrolled in the substance abuse programs they need to treat their addictions.

Twenty percent, or \$178,000, of the reduction will impact future investments in prevention efforts planned for 2013-15 in target population areas where there is a higher prevalence of substance abuse.

The Mental Health Block Grant is used as discretionary funding to support programs like peer-delivered services, such as Oregon Family Support Network and Youth M.O.V.E., supported education and other innovative pilot projects.

Sequestration will decrease Oregon’s Mental Health Block Grant allocation by approximately \$411,000. Sequestration will result in funding projects for just one year, instead of two, and limit the impact of projects.