Oregon Healthcare Workforce Committee

AGENDA – September 13, 2017 9:00 am – 12:30 pm
Oregon Tech
Room 402, 27500 SW Parkway Avenue
Wilsonville, OR 97070

Meeting Objectives:

- **Advance work on 2017-19 Charter Deliverables**
- **Hear relevant updates on state and federal policy changes**

#	Time	Agenda Item	Presenter(s)	Action Item
1	9:00 – 9:10	**Convene HCWF Committee, Introductions, Welcome**	David Pollack, Chair	
2	9:10 – 9:15	**Review:** July 12, 2017 Meeting Summary	David Pollack, Chair	
3	9:15 – 9:40	**OHA Updates**	Marc Overbeck, OHA	
4	9:40 – 9:50	**OHPB Update**	Carla McKelvey, OHBP Vice-Chair	
5	9:50 – 10:20	**Behavioral Health Update**	Jackie Fabrick, OHA Rusha Grinstead, OHA	
6	10:20 – 10:50	**Review and Discussion: Health Care Workforce Needs Assessment**	Tim Sweeney	
7	10:50 – 11:00	**Break**	All	
8	11:00 – 11:50	**HB 3261 (Health Care Provider Incentive Program) Rules Development**	Marc Overbeck, OHA Members	
9	11:50 – 12:05	**Other Emerging Items in Health Care Workforce Environment**	Members	
10	12:05 – 12:15	**Committee Recruitment**	Members	
11	12:15 – 12:25	**Public Comment**	Any	
12	12:25 -12:30	**Adjourn**: Next Meeting—November 8, 2017	David Pollack, Chair	

Meeting Materials

1. Agenda
2. Draft Meeting Summary from July 2017
3. Behavioral Health Updates (to be sent under separate cover prior to meeting)
4. Health Care Workforce Needs Assessment Outline
5. Proposed Rule—Health Care Provider Incentive Program

Oregon Healthcare Workforce Committee
July 12th, 2017
at Wilsonville Training Center
DRAFT - Meeting Summary

Committee Members in Attendance:	David Pollack, Chair David Nardone Daniel Saucy Jeff Clark Paul Gorman Maria Lynn Kessler Alisha Moreland Troy Larkin Curt Stilp	Robyn Driebelbis, Vice Chair (phone) Roxanna Ermisch (phone) Jane Irungu (phone) Kate Lee (phone) Jan Maybee (phone) Annette Fletcher (phone)
Committee Members not in Attendance:		
OHA staff, OHWI, OCN	Marc Overbeck, OHA Tim Sweeney, OHA Tiffany Granmo, OHA Stacey Schubert, OHA	Jackie Fabrick, OHA Royce Bowlin, OHA Stephanie Jarem, OHA (phone)
Others	Sheldon Levy, OHSU Rick Allgeyer, OCN Jana Bitton, OCN Sam Barber, Oregon Rural Health Association Robert Deuhmig, Oregon Office of Rural Health	

	Welcome
	David Pollack welcomed everyone to the meeting and proceeded with introductions. Jane Irungu informed the Committee that she was relocating to Oklahoma, and would have to leave the Committee. Members expressed appreciation for her service.
	Approval: Meeting Summary
	The meeting summary of May 3rd, 2017 was presented; Marc noted that Robert Duehmig was in attendance as a guest and had been omitted from the meeting summary, and would be added. No other corrections or revisions were offered.
	OHA Updates
	Primary Care Office Updates • Marc informed the Committee that HRSA communicated a change to the National Shortage Update just the previous day—the Update had been planned for July 26 and has now been rescheduled to November 4, 2017. At that time all geographic

	and population-based Health Professional Shortage Areas (HPSAs) in the nation will be updated. This is important because federal loan repayment awards and scholarships for clinicians in underserved areas are based on these HPSAs. The PCO has been correcting provider information in the federal system to ensure accuracy and that Oregon's clinicians have the best opportunity warranted for federal incentives. • Also, the application cycle has closed for clinical sites to participate. Received 24 and recommended 20 be approved and being reviewed in Seattle. Other Updates • Marc and Steph noted the departure of Lori Coyner as Medicaid Director and that David Simnitt has assumed the position of interim State Medicaid Director. Steph discussed the search for the new State Medicaid Director and for the Chief Medical Officer position, formerly held by Dr. Jim Rickards. Marc took additional questions on the federal loan repayment progams and HPSA scores.
	Behavioral Health Policy
	Royce Bowlin, Behavioral Health Policy Director • Royce shared his background, including his education and work in and interest in Community Mental Health efforts; he has been at OHA for 8 months and arrived just prior to the legislative session. He noted that one of OHA's top priorities is the work around behavioral health and the integration of BH and Primary Care and Public Health. • David Pollack clarified Royce's position in Oregon as the Single State Authority (SSA) for Mental Health. • Royce expressed confidence in the ability to develop a collective vision in Oregon and agreement on prioritizing what to focus on. Behavioral Health Collaborative • Royce and Jackie Fabrick spoke about the seven workgroups of the Behavioral Health Collaborative (Governance and Finance, Data, Standards of Care, Workforce, Peers, Consumer and Business Services, HIT). They noted that groups have meeting and developed strong guidelines and recommendations that will be coming to the Committee soon. The implementation of this work will be a priority in this next biennium. The intention is to have workgroup products that overlap with the Workforce Committee come back to the Committee for some discussion prior to moving to the Steering Committee. • The website for the BHC is up and running and all meetings/agendas available and open to public. Jackie noted David Pollack is participating on the Workforce Workgroup of the BHC.

	• Jackie spoke briefly about the contract with the Farley Center Assessment at University of Colorado to develop a BH Workforce Needs Assessment. The assessment is estimated to be completed within a year. • Stacey Schubert responded to Committee questions about the Workforce Data Reporting Program and the work being done now and anticipated with the various BH Licensing boards. It was noted that prior to July 2016 many boards were only voluntary reporters—this was changed and BH provider information will be available soon. • David Nardone and others spoke about the importance of estimating provider FTE and not simply relying on a count of licensees to assess the strength of the workforce.
	Legislative Updates
	• Marc expressed thanks to Sarah Lochner for her time and work this past session as HPA's legislative coordinator, and for all the updates she provided to the Committee during the session. • Marc reviewed the handout that Sarah provided at the previous meeting, updated since the end of the session. Nine key bills were tracked, related to the health care workforce. Most of these either passed as separate legislation or their concept was blended into another bill which did. Some highlights: o SB 178 – Extending the sunset on the rural medical provider tax credit—the content was incorporated into HB 2066 and approved. One change is there is a 10 year lifetime limitation for taking advantage of that credit. Sam Barber from ORHA added that there is also a 300K income cap for receiving credit for single or joint filer. (You don't get the stipend if your household income is above this.) o SB 856 – Naturopathic Medicine – Not identified as a prominent change in medical scope, but clarified pieces in statute where there was ambiguity or a question on the applicability to naturopathic doctors. Jeff Clark elaborated on naturopathic care. o HB 3261—Provider Incentive Reforms – Many concepts brought together. The Committee will continue to play a role for the OHPB in guiding the development of a new incentive program. Sen. Steiner Hayward's idea of a tax assessment to pay for training did not pass. The legislature did authorize up to $4 million to pay for activities which include training, and the Health Policy Board will contract with OHSU to initiate this. o HB 3341 – establishing a task force on rural training facilities did not pass, but was developed as a budget note. o HB3355 – Providing prescription authority for clinical psychologists passed, but there remains opposition to the idea.

	Alisha Moreland responded to the discussion regarding this bill and noted the importance of ensuring everyone "has the proper tools to do the job. " <u>HB3261</u> Marc discussed and elaborated on the PowerPoint slides regarding HB3261 – Changes to Provider Incentive Programs. He discussed the PowerPoint slides regarding HB3261 and took questions. Some topics: • Purposes of Provider Incentives • Key Elements of HB3261 • Programs Affected by HB3261
	Review and Discussion: HealthCare Workforce Reports
	• Stacey provided background on the Health Care Workforce Reports. In the past, the report program has published a very lengthy report (160 pages.) Health Analytics staff, in response to stakeholders, have been moving away from compiling lengthy reports and moving toward other means of disseminating available data where data can be used more effectively by researchers, policy makers and planners. Stacey invited the feedback of the Committee. • Stacey discussed and went through the highlights of the HealthCare Workforce Supply report. The Committee engaged in a discussion of the numbers in the Tables. • Marc and Stacey offered to hold a webinar for those members interesting in and able to look a bit more deeply at the reports. This meeting will be scheduled within the next month and members notified.
	Break Into Subcommittee Groups (Composition and Distribution)
	Committee members broke into two separate groups: Workforce Composition and Workforce Supply and Distribution for most of the rest of the session before returning for adjournment.
	Public Comment/Adjourn
	No public comment was offered. The next meeting is scheduled for September 6th, 2017 in Wilsonville. ***Note, this was revised afterward to September 13 ***

Next Meeting:
September 6th, 2017

Draft Outline for report examining workforce needs in Oregon, including what types of providers Oregon needs for the future and goals for the diversity of Oregon's health care workforce (Goal is for a 10-20 page report)

Background on Needs Assessment

Charge from HB 3261

(1) The Oregon Health Policy Board, in consultation with the Oregon Health and Science University and the Office of Rural Health, shall conduct an assessment of the health care workforce needs in this state, including but not limited to the health care workforce needed to address:
(a) The continuing expansion in commercial and publicly funded health care coverage;
(b) Health disparities among medically underserved populations; and
(c) The need for health care providers in rural communities.
(2) The board shall report to the Legislative Assembly no later than February 1 in each odd-numbered year on the health care workforce needs in this state and proposals for addressing those needs with programs funded by the Health Care Provider Incentive Fund established under ORS 676.450.

- Put the legislative charge into more plain language and preview how the report meets the legislative requirements
- Because the report will be issued again in 2019 and every other year after, this discussion could also include an effort to acknowledge shortcomings of this initial version while establishing additional goals and strategies for future reports
    - (in later sections, it may be worth identifying data and other gaps that would need to be addressed to expand the scope of the report in future years)

Charge from the Workforce Committee Charter

A report identifying the types of providers and diversity of providers desired for the future, based on previous work of the Committee, other OHA efforts, and academic literature within and outside of Oregon.

- (This section will clarify the interaction between legislative charge and initial deliverable and how current report meets the desires of the Board.)

What this is and isn't – Overview of the Report

Both the charge from legislature and the report included in the Committee charter are designed to inform state policy efforts to identify and address gaps in Oregon's health care workforce and the needs of communities lacking health care resources. In particular, the legislative charge envisions this report as a key product to inform the operation of the health care provider incentive fund also included in HB 3261.

There are barriers to the producing the report and limitations to its scope that should be presented and possibly explored further:

- Clear, consensus recommendations for how many providers of various kinds a community "needs" based on their population, demographics, or health status are limited if not nonexistent
- Creating thoughtful, quantifiable target ratios that take different community needs and characteristics into account would be time consuming and challenging
- A qualitative look about what the workforce should be able to do and how robust it should be is useful, but also is limited.

Assessing Health Care Workforce Needs

Defining the needs of the health care system is inherently difficult because different components of the health care system might define their "needs" in different ways. For instance, the need for a specific service could be defined at either the individual/patient level, the community level, or the provider level. This section of the report could note the differences inherent in defining needs at different levels, how various definitions can be useful as well as the limitations of each approach. In addition, the implications

for public policy of each of the different levels of needs could vary significantly, and should be well-understood to establish how these needs inform the implementation of the incentive programs in HB 3261.

One challenge is that current workforce gaps are sometimes better understood at the conceptual level than at the empirical level (because of the general lack of consensus benchmarks about what the system "should" look like). At the same time, distributional issues can present themselves as shortages in some areas, though shortages don't always exist in the big picture. Policy solutions that attempt to redistribute the current supply of health care resources will not enjoy the same broad levels of support that policy that seeks to grow overall capacity in a way that is designed improve capacity in existing shortage areas, and to improve the overall efficiency of provider distribution.

In particular, the following lenses could be used to examine the state's workforce needs:

- Industry demand for practitioners
- Patient access to care needs
- Community provider capacity needs
- Impact of workforce on health status (this could also be a standalone section)

- Lenses of Need
  - Industry demand
    - Economic demand for health care workforce by employers such as hospitals, clinics, and other facilities.
      - Large numbers of unfilled practitioner positions, for instance, can highlight an unmet need for specific skills or expertise.
      - Open positions can show geographic areas of need as well as workforce categories in need.
      - Measures of turnover could lend additional context, as can length of time positions remain unfilled in some geographies or fields.
      - Findings from employer interviews can lend an important qualitative component to measures of needs, including specific skills needed by individual practitioners.
    - Limitations to the conclusions to be drawn from this data
      - Demand for practitioners could be high in areas with most supply/ competitive markets
      - Motivation for needing new hires could be more financial than care-based
      - Doesn't take into account whether services are desirable from big picture policy level or whether they contribute to health or what they would need to do so
      - Doesn't take into account whether some patients (uninsured, Medicaid, Medicare) would benefit from new positions
  - Patient access lens
    - Measuring the workforce needs relative to patients seeking care provides another important lens to examining overall health care workforce capacity and needs. This analysis can highlight geographies where not enough providers are located to serve the local population and can examine this relationship for various practitioner types or specific services desired. There are many ways to measure ability of the workforce to serve the needs of the patients: using population to provider ratios, measuring time/distance from people to medical care
      - Patient Access to Primary Care Services—measured through availability of

providers (Provider Direct Patient Care FTE)
        - Total providers (Direct Patient Care FTE)
        - Provider workforce reflective of population needing service (identified on aggregate statewide and by county through ethnic demographics)
        - Availability of Specialty Care (see Rural Blueprint)
    - Limitations for this measure of need:
        - Access to health care services for individual patients are also dependent on their specific coverage type (private, Medicaid, Medicare, etc) or insurance carrier – some patients in areas that appear to have enough practitioners could face access hurdles.
        - Because patients can receive similar services from multiple types of providers, fewer providers of one type can be offset by larger numbers of other practitioner types with less negative impact on patients.
    - Patient access lens can also consider non-practitioner categories that help patients access medical care and/or remain healthier generally
        - THWs have been a particular focus and could be included
        - Health care interpreters and other categories of assisters who help enable better access to medical care
        - These categories are especially important in that they acknowledge that some workforce gaps need to be addressed in the short term for current patients / communities, even as efforts are also underway to close the gaps for future patients / communities
        - Role of telemedicine and how to set goals for its use / availability
- Community need for health care services
    - Similar to patient access lens, but a bit more "big picture." This look can involve tabulating the number of practitioners of various kinds serving geographic areas, either at the county or some other local level. This could be where to highlight data on the population-per-provider data across the state and in specific communities as well as other community-specific standards such as those included in Community Health Improvement Plans.
    - Demographic (race, ethnic, gender, and more) data can be presented to highlight current diversity gaps in Oregon's workforce
    - There are limitations in this method of measuring health care workforce needs:
        - Lack of easily identifiable, consensus recommendations for population to provider ratio for wide array of provider types
        - An acknowledgement that different provider types can provide similar / overlapping services, complicating the setting of population to provider goals
        - Ideal workforce could vary based on medical needs of communities based on demographics (age, for instance) and other location-specific variations in health issues.
    - This method of measuring need also has to acknowledge the difference between "desired workforce capacity" and the "needs" that public policy efforts should work to ensure. (ie, workforce capacity of communities will always vary and it is not feasible to use public policy levers to ensure equal capacity across every community of the state. Multiple threshold levels / tiers could be used to best direct resources – bare minimum levels, desired levels, reasonably aggressive goals…)

Trends:

- After establishing different ways to look at the workforce needed in Oregon, data can be looked at relative to recent population and demographic trends.
    - A closer look at the workforce needs should also consider recent and projected changes to Oregon's population and demographics.
        - This could include a qualitative discussion as well about the impact of a growing population and changing demographics on the types of providers needed – i.e., an aging population will require more gerontology, faster growing kids population more pediatrics, changing race/ethnic makeup requires a more diverse population, etc. Even though some of these may not be as easily put into quantifiable goals, the discussion can still be useful.
    - Population of Oregon by County 2010-2016
        - Total population and ethnic breakdown
        - Forecast of coming 5-10 years?
    - Workforce Expansion over time 2010-2016
        - By provider type
        - Combined physician/NP/PA
    - Goals can be established based on recent and projected population and demographic changes
        - Given the hurdles/difficulties establishing specific targets for patient-to-provider ratios, just keeping up with state trends (population and other, perhaps) can be a measurable goal. Or, goals for providers and diversity can be incremental to grow capacity by x-points faster than population growth to try and close current gaps
        - This lens could enable pro-active targets related to emerging demographic groups as well, so as to proactively mitigate future gaps and shortages.
    - Rise of Traditional Health Workers (THWs)
- How to include recent analytics workforce reporting data?

Health Status

Evaluating the health care workforce and health system capacity on its ability to keep people healthy is a long term goal, though it may be more difficult in the short term. In the short term, this could involve examining how lack of provider capacity negatively affects patient and community health in the places where health care provider shortages are most acute. This may be more complicated than simply comparing population health metrics with workforce data in given communities, as population health is influenced by so many factors outside the control of the health care system.

This section likely requires a delicate approach to set the state for future iterations of the report and to begin thinking about how to structure a health care workforce to maximize health and determine where there are existing gaps that have the biggest effect on health.

Other References:

- The report should build on previous work examining these issues from other partners. Examples include:
    - ORH Areas of Unmet Need Report Highlights:
        - Travel Time to PCPCH
        - Access to PC, BH, Oral Health services
    - OCN Report???

    - Ongoing work to establish a behavioral health workforce needs assessment by the BH Collaborative and its work with the Farley Center
        - This will not be completed in time for February 2018 report to legislature, but should be part of future reports and can help inform the follow-up work for 2019 submission.
    - Resources / assessments for workforce capacity standards from other states and/or countries that could be useful?

Likely Conclusions and Calls for Action:

- Insufficient Supply of Primary Care, BH and Oral Health Providers statewide
- Inadequate distribution of health care providers in rural and underserved communities—Primary Care and Specialty
    - As alluded to in the beginning, one strategy to address mal-distribution in the short term is to focus on increasing overall capacity with a specific focus on underserved areas. Underlying economic forces could exacerbate the maldistribution of providers even while gains are made addressing workforce shortage areas specifically.
- A health care workforce lacking in diversity.
    - Identifying the gaps in this area seem straight forward, and establishing goals that provider demographics align with patient demographics is a straight forward goal. Closing these gaps and establishing intermediate goals and strategies to achieve them may be more complicated.
- Many health care graduates are not team-ready
- Additional thoughts from the subcommittee and the full HCWF Committee
- Can incentive programs be used to support provider best practices – especially those that improve health – in addition to addressing workforce capacity issues

Other Items:

- Assessing how future versions of the report might for further than initial report in making recommendations and setting goals
    - What data might be needed to make future reports more robust
- Assessing the work that could be required to formulate a more comprehensive workforce needs assessment that includes quantifiable targets for communities across Oregon.

CHAPTER 409
OREGON HEALTH AUTHORITY, HEALTH POLICY AND ANALYTICS

DIVISION 36
HEALTH CARE PROVIDER INCENTIVE PROGRAM

409-036-0100
Purpose and Scope

The Legislature and Governor have authorized a program within the Oregon Health Authority to provide assistance to qualified health providers who commit to serving the health care needs of medical assistance and Medicare enrollees in both rural and non-rural underserved areas of the state.

The purpose of these rules is to set out parameters for the Healthcare Provider Incentive Program established under ORS 646.460.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0110
Definitions

The following definitions apply to OAR 409-036-0100 to OAR 409-036-0220:

(1) "Authority" means the Oregon Health Authority.

(2) "Carrier" means a medical professional liability insurer holding a valid certificate of authority from the Director of the Department of Consumer and Business Services (DCBS) that authorizes the transaction of insurance as defined in ORS 731.066(1) and 731.072(1), and does not include DCBS listed insurers pursuant to 735.300 to 735.365 and 735.400 to 735.495.

(2) "Clinical Psychologist" means an individual licensed to practice psychology pursuant to ORS 675.010 to 675.090.

(3) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to ORS 675.510 to 675.600.

(4) "Dentist" means any individual licensed to practice dentistry pursuant to ORS Chapter 679.

(5) "Eligible provider" means a practitioner in Oregon delivering health care services to patients in Oregon, who meets the provider participation requirements of OAR 409-036-0130 and who is:
  (a) A dentist in general or pediatric practice;
  (b) An expanded practice dental hygienist;

(c) A physician who practices or intends to practice in the specialties of family medicine, general practice, general internal medicine, geriatrics, pediatrics, or obstetrics and gynecology;

(d) A nurse practitioner who practices or intends to practice in the specialties of adult health, women's health care; geriatrics; pediatrics; psychiatric mental health; family practice, or nurse midwifery;

(e) A physician assistant who practices or intends to practice in the specialties of family medicine, general practice, general internal medicine, geriatrics, pediatrics or obstetrics and gynecology;

(f) A Naturopathic Physician

(g) A general, child and adolescent, or geriatric psychiatrist;

(h) A clinical psychologist;

(j) A clinical social worker;

(k) A Licensed Professional Counselor

(l) A Marriage or Family Therapist;

(m) A behavioral health professional who has completed a course of study and earned a degree but has not attained licensure;

(n) A Pharmacist;

(6) “Expanded Practice Hygienist” means an individual licensed to practice dental hygiene with an expanded practice dental hygienist permit issued under ORS 680.200.

7) “Licensed Professional Counselor” has the meaning given that term in ORS 675.715 to 675.765.

8) “Marriage and Family Therapist or Professional Counselor” has the meaning given that term in ORS 675.715 to 675.765.

(9) “Medical assistance” has the same meaning given that term in ORS 414.025.

(10) “Medicare” means medical coverage provided under Title XVIII of the Social Security Act.

(11) “Naturopathic Physician” means an individual licensed pursuant to ORS 685.010 to 685.135.

(12) "Nurse Practitioner" means any individual licensed pursuant to ORS 678.375.

(13) Office of Rural Health” (Office) has the same meaning given that term in ORS 442.475.

(14) “Pharmacist” has the meaning given that term in ORS 689.005.

(15) "Physician" means any individual licensed pursuant to ORS 677.100 to 677.228.

(13) "Physician Assistant" means any individual licensed pursuant to ORS 677.495 to 677.545.

(14) "Practice full-time" means working at least 40 hours per week, with a minimum of 32 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. Patient charting is considered a component of offering direct patient care. Telemedicine may be considered direct patient care when both the originating site (location of the patient) and the distant site (the eligible site where the provider works) are located in Oregon.

(15) “Practice part-time” means working at least 20 hours per week, with a minimum of 16 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. Patient charting is considered a component of offering direct patient care. Telemedicine may be considered direct patient care when both the originating site (location of the patient) and the distant site (the eligible site where the provider works) are located in Oregon.

(16) “Practitioner” means an individual qualifying for a rural liability insurance subsidy under the Program as noted in OAR 409-036-0330.

(17) “Provider” means an individual clinician eligible to participate in the Program.

(18) “Qualifying Loan” means one or more government or commercial loans received solely to cover the cost of post-baccalaureate health professional training, or, in the case of an expanded practice dental hygienist, undergraduate educational training. This does not include credit card loans, lines of credit, and personal loans.

(19) “Qualifying practice site” means:

(a) A rural hospital as defined in ORS 442.470 serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority;

(b) A federally certified Rural Health Clinic serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority;

(c) A Federally Qualified Community Health Center serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority.;

(d) A site other than those listed above providing primary care services to both Medicare and Medical Assistance enrollees in an area approved as a medical, dental or mental Health Professional Shortage Area (HPSA) as defined by the federal Health Resources and Services Administration; and serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority;

(e) A site other than those listed above providing primary care services to both Medicare and Medical Assistance that is located in an area in the lowest overall quartile of sites in the Office of Rural Health’s Assessment of Unmet Needs

report and serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority; or

(f) Any other site providing primary care medical, behavioral health or oral health services to an underserved population, as determined by the Authority and serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority**.**

(20) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0120
Types of Incentives Offered Under the Program

The types of incentives to be provided under this Program include:

(1) **Loan Repayment subsidies**

(a) Pursuant to ORS 676.460, an eligible provider may receive a loan repayment subsidy if they are not at the same time receiving loan repayment or forgiveness under a separate, competing service obligation.

(b) Loan repayment subsidies may be offered by the Authority in a manner which is based on the most recent Health Care Workforce Needs Assessment conducted by the Oregon Health Policy Board, as identified in Chapter 718, Oregon Laws, 2017.

(2) **Stipends** related to the health care workforce, as directed by the Oregon Health Policy Board that that Board determines can contribute to improved health of a community.

(3) **Loan Forgiveness payments**

(4) **Medical malpractice insurance premium subsidies**

(a) Payments from the Health Care Provider Incentive Fund may be made to subsidize health care practitioners for the cost of liability insurance premiums in force, or renewed on or after the Effective date of these Rules.

(b) A practitioner who has a rural practice that meets the criteria established by the Authority for the purposes of ORS 315.613 is eligible for a subsidy under the Program, if the practitioner:

(A) Holds an active, unrestricted license or certification;

(B) Is covered by a medical professional liability insurance policy issued by an authorized carrier with minimum coverage limits coverage of $1 million per occurrence and $1 million annual aggregate; and

(C) Is willing to serve patients with Medicare coverage and patients receiving medical assistance in at least the same proportion to the practitioner's total number of patients as the Medicare and medical assistance

populations represent in the county or service area as determined by the Authority.

(c) A nurse practitioner employed by a licensed physician is eligible for a subsidy if they are covered by a medical professional liability insurance policy that names and separately calculates the premium for the nurse practitioner.

(d) A practitioner whose medical professional liability insurance coverage is provided through a health care facility, as defined in ORS 442.400, and also meets the requirements of section (4) of this rule is eligible for a premium subsidy if the Authority determines that practitioner:

(A) Is not an employee of the health care facility;

(B) Is covered by a medical professional liability insurance policy that names the practitioner and separately calculates the premium for the practitioner; and

(C) Fully reimburses the health care facility for the premium calculated for the practitioner.

(e) Eligibility by individual practitioners to participate in the Program must be requested each year using an annual attestation provided to the Authority. Consistent with the requirements of this rule, the Authority shall establish criteria and procedures for making the eligibility determinations and for an annual attestation procedure that practitioners must use.

(f) The Authority shall forward to each of the authorized carriers participating in this Program, the list of eligible practitioners. The list shall include the practitioner's name, mailing address, specialty and applicable professional license or certification number issued by either the Board of Medical Examiners or the Board of Nursing;

(g) Each carrier must provide its participating practitioners with the following information each quarter is in effect:

(A) The quarterly premium due before the premium subsidy is applied;

(B) The amount of the premium subsidy; and

(C) The premium after the premium subsidy is applied.

(h) The carrier shall display these three figures on each participating practitioner's billing Statement.

(i) If the funds available for the Program in the Rural Medical Liability Subsidy Fund are insufficient to provide the maximum premium subsidy for all qualifying Practitioners who have applied, the Authority may reduce or eliminate subsidies for practitioners in an equitable manner. If the Authority must take any of the actions described in this rule due to insufficient funds to pay a premium subsidy, the Authority shall inform the affected participants and carriers about the action. A carrier shall reduce the premium charged to a practitioner by the amount of any premium subsidy paid or to be paid under this Program.

(j) To participate in the Program carriers must provide written notice and certification to the Authority not less than 30 days prior to the beginning date of a calendar quarter. The initial carrier written notification and certification must be signed by an individual authorized to represent the carrier and delivered to

the Authority at the following address: Oregon Health Authority, 500 Summer St NE, E-44, Salem, OR 97301, and Attention: Rural Medical Practitioners Insurance Subsidy Program.

(A) The written notification must certify that the carrier:

(i) Is a medical professional liability insurer holding a valid certificate of authority from the Director of DCBS that authorizes the transaction of insurance as defined in ORS 731.066(1) and 731.072(1), and does not include DCBS listed insurers pursuant to 735.300 to 735.365 and 735.400 to 735.495;

(ii) Understands that the Authority may confirm the representations in paragraph (B) with DCBS, and that DCBS' determination about whether the carrier holds a valid certificate of authority to engage in professional liability insurance in the state of Oregon and the other criteria in paragraph (A) shall be relied upon by the Authority in determining whether an insurer is an authorized carrier and

(iii) That the carrier agrees to comply with the terms and conditions of the rules applicable to this Program in effect at the time of initial certification and those rules in effect when any request for subsidy payment is submitted to the Authority for payment.

(iv) The Authority shall confirm in writing that the carrier meets the criteria as an authorized carrier. If the Authority determines that an entity is not eligible to participate as a carrier, the Authority shall provide notice to the entity of its determination and shall deny participation in the Program. The Authority shall handle a request to appeal that determination in accordance with the procedure for administrative review described in OAR 410-500-0060.

(B) If an insurer fails to provide the notice and certification to the Authority within the time established, the insurer may not submit a request for premium subsidy payment for the next calendar quarter and insurers otherwise eligible practitioners may not receive a premium subsidy for that quarter.

(C) An authorized carrier must provide, and continue to provide, to the Authority accurate, complete and truthful information concerning their qualification for participation in the Program. A carrier must notify the Authority in writing of a material change in any status or condition that relates to their eligibility to participate in the Program.

(k) If a carrier decides to discontinue participation in the Program, the carrier shall notify the Authority at least 90 days prior to the beginning date of the next calendar quarter. The carrier shall notify its insured participating practitioners of its intent to not participate at least 60 days prior to the date of the next calendar quarter.

(l) The Authority may determine that funds available for the Program are insufficient to provide maximum premium subsidy for all qualified practitioners, and the Authority may reduce or eliminate subsidies. There is no guarantee of any amount of premium subsidy that may be provided to any carrier.

(m) Within 30 days after the end of each billing period, monthly or quarterly, each carrier must electronically, (using Microsoft Excel or similar spreadsheet application) submit a report to the Authority showing the following information for each eligible practitioner who has been determined eligible for a premium subsidy as of the end of the billing quarter under this Program.

(A) The information must include the following:

(i) Carrier's name;

(ii) Practitioner's name and, for each practitioner:

(I) Oregon Board of Medical Examiners license number or Oregon State Board of Nursing certification number;

(II) Practitioner's specialty and specialty class;

(III) Insurance Services Office (ISO) code;

(IV) Policy number and effective date;

(V) Billing period coverage start and end dates;

(VI) Billing frequency (annually, quarterly, monthly);

(VII) Current in-force annual premium for coverage limits of $1 million per occurrence and up to $3 million annual aggregate;

(VIII) Premium subsidy percentage, calculated in accordance with section (3) of this rule;

(IX) Dollar amount of premium subsidy, calculated in accordance with these rules;

(X) Explanation of any adjustments under this Program from previous reports;

(XI) Policy coverage limits;

(XII) Claims-made step of practitioner, if applicable.

(XIII) Identification of practitioners who were not on the eligible list at the beginning of the quarter, including all of the information in subparagraphs through this rule for eligible practitioners;

(B) Each January all carriers must provide the Authority with a copy of its base rates and increased limits factors table. The carrier must also inform the Authority of the base rates and increased limits factors table from their current rate filing for Oregon within 30 days of any change to those rates and table.

(C) A carrier must submit true, accurate, and complete report or rates.

(D) Failure to make a timely submission may result in delay in processing the payment request. The Authority shall calculate the payment of premium subsidies from the Rural Medical Liability Subsidy Fund based on the funds available for the applicable billing period. In the event of

insufficient funds, the risk of carrier delay in submission of a request for subsidy payment is on the carrier, because payments shall be based on the subsidy requests received timely for each applicable billing period.

(5) **Scholarships for students in health professional training programs at the Oregon Health and Science University** will make available scholarships in a manner consistent with ORS 348.303,

(6) **Scholarships for students in health professional training programs at other institutions of higher learning** not governed by ORS 348.303 may make available scholarships using rules developed by the institution and reviewed by the Authority.

(7) **Moving expenses for providers** who move in order to practice in an underserved area.

(8) **Incentives to qualifying practice sites** to support recruitment and retention of providers who will deliver care that supports the opportunity for people to be healthy

(9) **Other incentives** as identified and directed by the Oregon Health Policy Board

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0130

Participation and Application Requirements

(1) Program participants who are clinicians must agree to serve Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority.

(2) Program participants who are clinicians must commit to practice either full-time in a qualifying practice site for at least three years or part-time in a qualifying practice site for at least five years.

  (a) Full-time in a qualifying practice site for at least three years. Full-time participants may offer to practice for as many as twelve years, and the Authority may enter into contract with them for such a period of time.

  (b) Part-time in a qualifying practice site for at least three years. Part-time participants may offer to practice for as many as twelve years, and the Authority may enter into contract with them for such a period of time.

(3) To qualify for consideration in the Program, a primary care provider must submit an application that:

  (a) Documents the individual having, or having applied for, an unrestricted license to practice in Oregon within their discipline;

  (b) Includes a signed and dated statement certifying that the individual is not currently participating in the National Health Services Corps (NHSC), Nursing Corps, or State Loan Repayment Programs or the NHSC Scholarship Program or other current service obligation;

(c) Attests to the number of years that the individual is willing to make a service commitment of at least three years' work in a qualifying practice site, during which time the individual agrees to serve Medicaid patients in the same approximate proportion of the patients in the county or other service area, up to a maximum of 15 percent of patient mix; and

(d) Provides all other information required by the Program to determine the suitability of making an award from program funds.

(4) If an applicant for loan repayment subsidies is currently employed at an eligible practice site or has an employment contract with an eligible practice site, the applicant shall submit a letter attesting the site meets the definition set out in OAR 409-037-0010 (14) and provide other information as requested by the Authority.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0140
Application and Review Process

(1) As of the effective date of the filing of this proposed rule, the Program is still developing application processes. When the Authority has finalized the process, the Authority shall provide application format and submission requirements on the Program website.

(2) The Authority shall review those applications that meet all requirements of OAR 409-036-0020.

(a) The Authority shall return incomplete applications, and these shall be processed upon return as of the new date of receipt when they are determined complete.

(b) The Authority shall notify applicants of the status of their completed applications within 90 days of application submission.

(3) The following factors may be considered in determining whether to accept an eligible provider for participation in the program, including but not limited to:

(a) **Provider type.** Providers who may be counted as primary care medical, dental, or mental health providers in determining federal HPSA designations may be given priority consideration for Program participation. This will not disqualify others from eligibility, as noted above.

(b) **Determined need of the area**. The Authority may prioritize applications from providers who apply to practice at a qualifying practice located in a higher scoring HPSA (14 and above) that may not reach the threshold for federal NHSC or NurseCorps awards in a given year.

(c) **NHSC certification status** of the practice site. The Authority may prioritize applications from providers committing to practice at a qualifying practice site that is certified to meet the requirements of the National Health Service Corps.

(d) **PCPCH status of the practice site**. The Authority may award priority to eligible providers who will provide services in, or in affiliation with, a Patient Centered Primary Care Home (PCPCH) recognized by the State of Oregon.

(e) **Duration of time committed to practice site, or to serving in Oregon**. The Authority may give providers priority for an award based on the duration of time they commit to serve at their practice site or in the state.

(f) **Provider types, disciplines, or ethnic or linguistic diversity particularly needed in a community.** The Authority may give providers priority for an award who meet specific needs identified by a community, including ethnicity, language spoken, specialty or provider type.

(g) **Community willingness to contribute to the cost of the award.** The Authority may give providers priority for an award if a practice site or community agrees to share in the cost of the incentive at the time of application.

(4) The following factors may be considered in determining whether to accept a clinical practice provider for participation in the program, including but not limited to:

(a) NHSC certification status of the practice site

(b) PCPCH Status of the practice site

(c) The practice site being the sole provider of primary care medical, oral health or behavioral health services in a given area as determined by the Authority.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-037-0150

Maximum Award Amounts

(1) Loan repayment subsidy recipients are eligible for a maximum loan repayment award in the following manner:

(a) Full-Time Service:

(A) Fifty percent of the balance owed on qualifying loans upon program entry for three years of service with a maximum;

(B) Seventy percent of the balance owed on qualifying loans upon program entry for five years of service;

(C) Ninety percent of the balance owed on qualifying loans upon program entry for seven years of service;

(D) A participant may receive no more than $40,000 in a single year for full-time service.

(b) Part-Time Service:

(A) Twenty-five percent of the balance owed on qualifying loans upon program entry for six years of service with a maximum;

(B) Thirty-five percent of the balance owed on qualifying loans upon program entry for five years of service;

(C) Fifty-percent of the balance owed on qualifying loans upon program entry for seven years of service;

(D) A participant may receive no more than $25,000 in a single year for part-time service.

(2) Scholarship and Loan Forgiveness recipients:

(a) Scholarship recipients under the Scholars for a Healthy Oregon Initiative at Oregon Health and Science University shall receive a scholarship covering the entire cost of tuition and fees for the participant's health care education at the university.

(b) Students attending other educational institutions shall receive a scholarship or loan forgiveness covering an amount equal to at least half of and up to the entire cost of tuition and fees for the participant's health care education in the program in which they are participating, at the discretion of the institution, so long as the maximum scholarship for each student does not exceed the highest resident tuition rate at the publicly funded health professional training programs in this state.

(3) Insurance Subsidy Recipients. Practitioners in the Program who receive an insurance subsidy shall receive a maximum subsidy of:

(a) Eighty percent of the actual premium charged for physicians specializing in obstetrics and nurse practitioners certified for obstetric care;

(b) Sixty percent of the actual premium charged for physicians specializing in family or general practice who provide obstetrical services;

(c) Forty percent of the actual premium charged for physicians and nurse Practitioners engaging in one or more of the following practices:

(A) Family practice without obstetrical services;

(B) General practice without obstetrical services;

(C) Internal medicine;

(D) Geriatrics;

(E) Pulmonary medicine;

(F) Pediatrics;

(G) General surgery; or

(H) Anesthesiology;

(d) Fifteen percent of the actual premium charged for physicians and nurse practitioners other than those included in sections (3) (a) i – iii

(4) Other subsidies. The Authority may provide other subsidies of up to $100,000 to providers for moving expenses, housing, or other purposes, upon application from a provider that is supported by a written statement from an eligible practice site. Nothing in this section is intended to preclude a provider from receiving more than one type of incentive under the Program.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0160

Transfer of Provider Service Obligation to another Site

(1) In the event of a practice failure or other extenuating circumstance, a participating provider may, with Authority approval, transfer his or her service obligation to another qualifying practice site. This is intended to be a rare instance and will not be granted without prior approval. A written transfer request must be submitted to the Authority documenting the:
   (a) Circumstances surrounding the need to transfer;
   (b) Proposed new qualifying practice site; and
   (c) The name of the director or administrator at the proposed new practice site.

(2) Along with the written transfer request, the participating provider must submit:
   (a) A letter from the original practice site releasing the eligible provider from any employment contract (if applicable) and providing an explanation for the termination of employment. The Authority may waive this requirement if the original practice site is in non-compliance with federal requirements, federal or state law, or these rules.
   (b) An employment contract with the new qualifying practice site, a letter of intent from the new qualifying practice site to employ the provider, or documentation of the provider having established a sole proprietorship, Limited Liability Corporation, Limited Liability Partnership, or Professional Corporation that meets the definition of a qualifying practice site.

(3) The new practice site, in collaboration with the provider, must:
   (a) Submit a letter of support documenting the site meets the definition in OAR 409-036-0200 (19) and providing other information as requested by the Authority.
   (b) Provide confirmation that the site will cooperate with the provider to comply with the monitoring and follow-up requirements set forth in these rules.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-033-0170

Suspension or Waiver of Minimum Service Obligation

(1) The Authority may agree to suspend a participating provider's service obligation for a specified period of time under circumstances it deems appropriate, including, but not limited to parental leave, medical leave, military service leave, or other factors beyond a provider's control. During the time of suspension, awards are also suspended.
(2) A participant requesting a suspension of minimum service obligation shall make a written request to the Authority, citing the reasons and providing documentation of the circumstances.
(3) The Authority may waive all or part of the minimum service obligation under the following circumstances:
    (a) Upon receipt of written documentation acceptable to the Authority of the death of the participant;
    (b) Upon receipt of written documentation acceptable to the Authority of the total and permanent disability of the participant; or
    (c) Upon receipt of documentation of other significant changes in life circumstances that are out of the control of the participant and that the Authority determines warrant a waiver of service commitment.
(4) If all or part of the minimum service obligation is waived, the Authority may not impose any penalty for failure to meet the obligation.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0180
Monitoring and Follow-up Requirements

(1) To maintain participation in the Program, a provider must:
    (a) Notify the Authority immediately upon beginning work at a qualifying practice site.
    (b) Promptly submit semi-annual reports signed by the provider and the administrator of the qualifying practice site verifying the provider's employment, or licensed business, in the case of a sole provider, and providing any additional information as requested by the Authority, including but not limited to:
    (c) Site's and Provider's caseload (panel size or equivalent);
    (d) Site's and Provider's Medicaid caseload and Medicare caseload;
    (e) Provider full time equivalent (FTE) status; and
    (f) Number and percentages of practice site's patients whose health care is covered by Medicaid and by Medicare, as well as the number of patients at the practice site who are uninsured.
(2) The first report is due six months after employment begins, and every six months thereafter, until the term of the contract is complete.

(3) A provider participating in the Program must notify the Authority immediately of any change in employment or practice status.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-037-0190
Failure to Comply; Penalties

(1) A participant who fails to complete the minimum service obligation in a qualifying practice site and does not receive a waiver shall be considered to have breached the terms of the Program. The Authority shall impose a penalty on any such provider in an amount up to the sum of:
   (a) The total paid from the Health Care Provider Incentive Fund to the participant or on behalf of the participant for any periods of obligated service not served;
   (b) $7,500 for each month of the minimum service period not completed according to the terms of the obligation; and
   (c) Interest on the above amounts at the maximum prevailing rate, as determined by the Oregon Department of Revenue, calculated from the date of breach until full repayment has been made.

(2) Any amount determined to be due under this section shall be collected by the Collections Unit in the Oregon Department of Revenue under ORS 293.250.

(3) A participant may appeal decisions made by the Authority under the provisions of ORS Chapter 183.

(4) A carrier who is found to be in breach of their agreement under this program is subject to penalties. Administrative review, for purposes of these rules, shall be the process for any appeals made to the Authority. A carrier or practitioner may request administrative review. The request must be received by the Authority not later than 30 calendar days after the date of the Authority's notice. If the request for administrative review is timely, the practitioner or the carrier must provide the Authority with a copy of all relevant records and other materials relevant to the appeal, not later than 10 days before the review is scheduled.
   (a) If the Administrator or designee decides that a preliminary meeting between the practitioner or carrier and Authority staff may assist the review, the Administrator or designee shall notify the individual requesting the review of the date, time, and place the meeting is scheduled.
   (b) The administrative review meeting shall be conducted as follows:

      (A) Conducted by the Administrator, or designee;
      (B) No minutes or transcript of the review shall be made;

(C) The carrier or practitioner requesting review does not have to be represented by counsel during an administrative review meeting and shall be given ample opportunity to present relevant information;
(D) Authority staff shall not be available for cross-examination, but may attend and participate in the review meeting;
(E) Failure to appear without good cause constitutes acceptance of the Authority's determination;
(F) The Administrator may combine similar administrative review proceedings and meetings involving the same parties or similar facts, if the Administrator determines that joint proceedings may facilitate the review;
(G) The Administrator or designee may request the practitioner or carrier making the appeal to submit, in writing, new information that has been presented orally. The Authority shall establish the deadline for submission of the information.

(c) The results of the administrative review shall be sent to the participant involved in the review, within 30 calendar days of the conclusion of the administrative review meeting, or such time as may be agreed to by the participant or designated by the Authority.
(d) The Authority's final decision on administrative review is the final decision on appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Authority's final decision on administrative review.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0200
Contributions to the Health Care Provider Incentive Fund

(1) The Authority shall publish on its website terms and conditions for receipt of funds from qualifying practice sites or other sources to contribute toward the cost of the subsidies for participants.
(2) Contributions shall be deposited to the Health Care Provider Incentive Fund established in ORS 676.450.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409 – 036-0210
Program Integrity
(1) The Authority shall analyze and monitor the operation of the Program and audit and verify the accuracy and appropriateness of all payments made under the terms of this

Program. To promote the integrity of the program, the Authority may require participants and any other parties to develop and maintain adequate financial and other documentation as determined by the Board to be necessary. The Authority may communicate with and coordinate any program integrity actions with the federal and state oversight authorities.

(2) When the Authority determines that an overpayment has been made to any individual or carrier, the amount of overpayment is subject to recovery. The Authority may take appropriate action to redress payment errors or false claims for payment under the Program.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0220
Data Sharing

(1) For purposes of planning or analysis, the Authority may share de-identified, aggregate and individual-level health care workforce data about participants in the program with other state agencies, including but not limited to:

(a) Agencies, offices, or contractors of the Oregon Health Authority.

(b) The Oregon Employment Department.

(2) The Authority may not provide data sets to a non-governmental agency except as noted above without written approval from the Director of the Authority.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718