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Beneficiary Cost Sharing in Medicare Advantage Varies from Traditional Medicare[1]

Inpatient Hospital*

Plan & Length of Stay	Hospital Cost Sharing	Out of Pocket Costs
Traditional Medicare Benefit National Average LOS: 5.8 days	• **$992 single deductible for days 1-60** • **$248 per day for days 61-90** • **60 "lifetime reserve" days at $496 per day** • **$496 per day for each "lifetime" day over 90 days per episode (max 60 for lifetime)**	**$992**
Secure Horizons HMO New York, NY Average NY LOS: 7.5 days	• $325 copay per day for day 1-9 • No copay after day 9 • No limit on number of days	$2600
Universal Health Care, Inc. St. Petersburg, FL. (HMO) Average FL LOS: 5.8 days	• $300 copay per day for day 1-7 • No copay for days 8-90 • $476 copay per day for each "lifetime" day over 90 days per year (max 60 for lifetime)	$1800
Physicians United Plan Winter Haven, FL (HMO) Average FL LOS: 5.8 days	• $325 copay per day for day 1-7, • Days 8 through 90 no copay. • 90 day maximum benefit	$1950

Skilled Nursing Facility*

Plan & Length of Stay	SNF Cost Sharing	Out of Pocket Costs
Traditional Medicare Benefit National Average LOS: 26 days	**After hospital stay of at least 3 days:** • **$0 copay for days 1-20** • **$124 per day for days 21-100** • **100 day cap per benefit period**	**$620**
InStil Health Insurance Company **Columbia, SC. (PFFS)** National Average LOS: 26 days	After hospital stay of at least 3 days: • $0 copay for days 1-5 • $75 copay per day for days 6-100 • 100 days per benefit period	$1575
MediSun Private Fee for Service **Sun City, AZ (PFFS)** National Average LOS: 26 days	• $50 copay per day for days 1-20 • $100 copay per day for days 21-100 • 100 days per benefit period	$1600
Advantra Freedom **Houston TX (PFFS)** National Average LOS: 26 days	• $0 copay for days 1-3 • $90 copay per day for days 4-100	$2070
Humana Gold Choice **Louisville, KY (PFFS)** National Average LOS: 26 days	• $0 copay for days 1-6 • $125 copay per day for days 4-100 • 100 days per benefit period	$2750

Home Health

Plan	Home Health Cost Sharing
Traditional Medicare Benefit	• **No Out of Pocket Expense** • **No prior authorization required** • **Must be restricted to home and need intermittent skilled care**
SelectCare of Texas Houston, TX. (HMO)	• 20% of per-visit cost. • Requires pre-authorization
InStil Health Insurance Company Columbia, SC. (PFFS)	• 20% of per-visit cost
WellPoint Private Fee for Service Plans (PFFS): Anthem Blue Cross & Blue Shield Blue Cross and Blue Shield of GA. Unicare Life & Health Insurance Co. Anthem Insurance Companies, Inc. Blue Cross & Blue Shield of CO Blue Cross & Blue Shield of WI	• 15% of per-visit cost
Sterling Life Insurance Co. Bellingham, WA. (PFFS)	• 15% of per-visit cost

Durable Medical Equipment (DME)

Plan	Durable Medical Equipment Cost Sharing
Traditional Medicare Benefits	• **20% copay on Medicare approved DME** • **No prior authorization required.**
Secure Horizons Maryland Heights, MO (HMO)	• 30% copay on Medicare approved DME
HealthNet of AZ Tempe, AZ (HMO)	• 30% copay on Medicare approved DME • Pre-authorization rules apply.
WellPoint Plans (PFFS): Anthem Blue Cross & Blue Shield Blue Cross and Blue Shield of GA. Unicare Life & Health Insurance Co. Anthem Insurance Companies, Inc. Blue Cross & Blue Shield of CO Blue Cross & Blue Shield of WI	• 30% copay on Medicare approved DME under $750 • 20% of charges for DME item over $750
WellCare Tampa, FL (PFFS)	• 25% copay on Medicare approved DME benefit

Inpatient Mental Health

Plan	Inpatient Mental Health Cost Sharing
Traditional Medicare Benefits	• **$992 single deductible for days 1-60** • **$248 per day for days 61-90** • **$496 per day for each "lifetime" day over 150 days per year (max 60 lifetime days)** • **Overall lifetime cap of 190 days in psychiatric hospitals** • **190 day lifetime limit on inpatient psychiatric**
MediSun Private Fee for Service Sun City, AZ (PFFS)	• $250 copay per day for day(s) 1 - 8 in a Medicare-covered hospital. • For longer hospital stays: • Days 9 - 30: 0 copay per day • Days 31 - 90: $300 copay per day • Copayments may vary based on facility. • 190 day maximum lifetime limit..
Medical Health Plans Inc. Coral Gables, FL (PSO)	• $175 copay per day for days 1-5 • No copay for days 6-90 • 190 day lifetime limit in psychiatric hospital • Requires Preauthorization
Desert Canyon Community Care Prescott, AZ (HMO)	• $200 copay per day for days 1-5 • No copay for days 6-90 • 190 day lifetime limit in psychiatric hospital • Requires Preauthorization
Community Care Plans Little Rock & Fayettsville AR (HMO)	• $250 copay per day for days 1-5 (depends on plan) • $0-$50 copay per day for days 6-90 • 190 day lifetime limit in psychiatric hospitals • Requires pre-authorization.
Community Care Plans: Spokane and Kennewick, WA (HMO)	• $200 copay per day for days 1-5 (depends on plan) • No copay for days 6-90 • 190 day lifetime limit in psychiatric hospitals • Requires pre-authorization.

NOTE: Plan locations listed are for headquarters only. Plans' business markets may vary.
** Aggregate utilization data available for inpatient hospital and skilled nursing only.*

Sources

[1] Plan information derived from CMS Data: "MPPF – Medicare Advantage Data" Last accessed 5/10/07 online: http://www.medicare.gov/Download/DownloadDB.asp

The Federal Government's Role in Health Care Workforce Development and Distribution

Federal Laws Committee
Oregon Health Fund Board
April 22, 2008

Jo Isgrigg, Ph.D.
Executive Director
Oregon Healthcare Workforce Institute

Overview

Federal issues related to increasing or maintaining Oregon's health care workforce to enable the medical home model to work.

- Oregon's provider picture
- Federal role in health professions education and distribution

Oregon's Provider Picture

- **Physicians**
  - Over **15,000** licensed physicians in Oregon.
  - April, 2008, Oregon Medical Board reports **10,934** active licensed physicians, of which **4,240** are in primary care specialties.
  - 2006 OHPR study identified **8,151** active licensed physicians.
  - 2006 OED/BLS employer survey projected **6,751** physician workforce (all specialties) growing to **8,927** in 2016 (32% growth rate).
  - Combining growth and replacement data, OED projections show Oregon needs **322 new physicians per year from 2006-2016**.

- **Physician Assistants**
  - As of April, 2008, the Oregon Medical Board currently has **769** licensed physician assistants on record.
  - **317** physician assistants have identified primary care practices.
  - The 2006 OED/BLS employer survey projected **613** in the PA workforce growing to **967** in 2016 (58% growth rate).
  - OED growth and replacement projections show a need for **48 new PA's per year from 2006-2016.**

Oregon's Provider Picture

- **Dentists**
  - Currently, **3,643 dentists** licensed by the Board of Dentistry.
  - 2006 OED/BLS employer survey projected **1,239** dentist workforce growing to **1,508** in 2016 (**22% growth rate**).
  - OED growth and replacement data show a need for **60 new dentists per year between 2006-2016.**

- **Dental Hygienists**
  - Currently, **3,440 dental hygienists** licensed by Board of Dentistry.
  - 2006 OED/BLS employer survey projected **3,032** dental hygienist workforce growing to **3,957** in 2016 (30.5% growth rate).
  - OED growth and replacement data show a projected need for **122 additional hygienists per year** between 2006-2016.

Oregon's Provider Picture

- **Nurses**
  - As of April 1, 2008, the Oregon Board of Nursing reports **42,877** licensed registered nurses in Oregon.
  - The Oregon Center for Nursing reports that an additional **15,700** RN job openings are expected statewide over the next 15 years.

- **Advanced Practice Nurse Licenses** (August, 2007)
  - Acute - 27
  - Adult - 321
  - Family - 926
  - Geriatric - 44
  - Neonatal - 42
  - Nurse Midwife - 236
  - Pediatric - 154
  - Psychiatric/Mental Health – 350
  - Women's Health - 128

Key Federal Agencies

- Department of Health and Human Services
- Department of Labor
- Department of the Interior/Indian Health Service
- Department of Veterans Affairs
- Department of Defense
- Department of State
- Department of Education
- Federal Communications Commission

Federal roles in health care workforce development and distribution

- Fund individuals
- Fund institutions
- Recruit
- Educate
- Import
- Protect
- Reimburse

Fund Individuals

- National Health Service Corps Scholarship Program
- Nursing Scholarship Program
- Scholarships for Disadvantaged Students
- Loans for Disadvantaged Students
- Indian Health Service Scholarship Program
- Armed Forces Health Professions Scholarships
- Uniformed Services University of the Health Sciences Scholarship Program
- National Institutes of Health Undergraduate Scholarship Program

Fund States and Institutions

Health Resources and Services Administration

- Centers of Excellence
- Health Careers Opportunity Program
- Training in Primary Care Medicine and Dentistry Program
- Area Health Education Centers
- Geriatric Programs
- Public Health, Preventative Medicine and Dental Public Health Program
- Advanced Nursing Education

Department of Labor

- Workforce Investment Act
- Community-Based Job Training Grants
- President's High Growth Job Training Initiative

Federal Communication Commission

- Rural Health Care Pilot Program

Recruitment (Distribution)

- National Health Service Corps Loan Repayment Program
- Nursing Education Loan Repayment Program
- Faculty Loan Repayment Program
- Nurse Faculty Loan Repayment Program
- Indian Health Service Loan Repayment Program
- NIH Clinical Research Loan Repayment Program

Education

- Veterans Health Administration
  - Internships, residency programs
  - Nursing Academy Enhanced Academic Partnerships Program
- Department of Defense Military Health System
  - Uniform Services University of the Health Sciences
  - U.S. Army Academy of Health Sciences
  - Navy Medical Department GME

Import (Medical Migration)

U.S. Immigration Policy/Department of State

- International Medical Graduates (IMG)
- Foreign nurse migration
- J-1 Exchange Visitor Physician
- B-1, B-2 Temporary visitor
- F-1 Student
- H-1, H1b,H-2, H-3 temporary worker

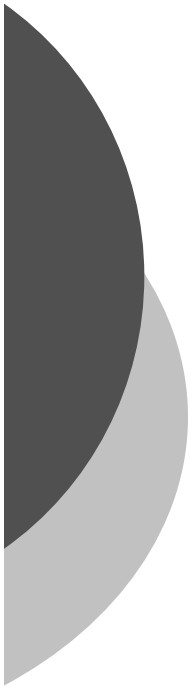
Protect

National Practitioner Data Bank

- Title IV of Public Law 99-660, the Healthcare Quality Improvement Act of 1986.
- Intended to keep unprofessional or incompetent practitioners from moving from State to State without disclosure or discovery of previous damaging or incompetent performance.
- Information on:
  - adverse licensure actions;
  - clinical privileges actions;
  - professional society membership actions;
  - paid medical malpractice judgments and settlements;
  - exclusions from participation in Medicare/Medicaid;
  - actions taken by the Drug Enforcement Administration.

Role for State in Federal Health Care Workforce Development and Distribution Activities

- In obtaining accurate information on Oregon's existing healthcare workforce
  - Data collection via the health professions' licensing process
- In allocation of federal health care workforce development funding to states
  - Support for pipeline, incumbent training and pathways, ongoing skills development, residency training, infrastructure
  - Consider redesign of federal health care education grant funding – to states for allocation based on state's workforce need
- In recruiting for specialty and geographic distribution and under-represented populations
- In influencing federal criteria for program eligibility
  - Impacting eligibility for individuals, institutions, etc.
- In support of federal funding for telemedicine networks
  - Interstate credentialing of telemedicine providers



Questions?

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Health care reform, provider education and a federal regulatory quirk

Presentation to the Oregon Health Fund Board Committee on Federal Laws

Mark Richardson, M.D., M.B.A., Dean, OHSU School of Medicine
April 22, 2008

Consensus on the problem

- Provider shortages
- Regional mal-distribution
- Increasingly affecting everyday life
  - Can't find physicians, weeks to wait for appointments, long travel times to specialists…
- Today's presentation focuses on physicians, but action needed for all

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The impact of shortages on reform efforts

- Meaningful health care reform depends on a robust provider workforce
- The concept of a “medical home” is ineffective with provider shortages
- Health care reform must find ways to fund the size/quality of provider workforce needed for success
- Federal law creates an opportunity

The Massachusetts example

- “*In Massachusetts, Universal Coverage Strains Care*” – New York Times, April 5, 2008
- 340,000 new uninsured people gained coverage
- No corresponding increase in providers
- Cites doubling of wait time to 3 months for general physical

Physician supply is declining

- Flat med school graduation (no increase in educational capacity)
- Aging physician workforce (retirement)
  - Nearly half of Oregon's physicians are 50+ years
  - 22% will retire within 5 years
- Shifting lifestyle expectations
- Malpractice insurance costs
- *Capped residency training opportunities*

Source: Oregon Office of Health Policy and Research, 2006, AAMC, OBME

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Oregon fundamentals are strong

- OHSU's primary care, family medicine programs ranked second in the nation
- Physician retention rates are high ~ 50% remain
- Our grads buck national trends – still selecting primary care
- The "ingredients" are present
- Time to "cook" them by partnering for expanded education capacity

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Federal law “capped” residency training slots

- 1996 Balanced Budget Act “capped” post-MD training positions
  - For all existing programs
  - No opportunity to expand at OHSU
  - OHSU has 676 post-MD training positions
- The QUIRK: the law allowed for *new* training programs
- *And* federal law provides funding for new training programs

The GME challenge and the opportunity

- Challenge: Smaller, regional hospitals lack administration, curriculum, accreditation support
- Opportunity: The Graduate Medical Education Consortium
- Three essential steps
- But first, some data

OHSU School of Medicine graduate data

- 120 medical student graduates per year
  - About 5,000 applications per year
  - 7% (350) of applicant pool is Oregonian
  - Current class is 70% Oregonians
- 200 GME trainees complete their training each year

Recent data show high percentage of OHSU grads remain in Oregon

- 52% of OHSU medical students stay in Oregon
  - Average nationwide is 40%
  - OHSU ranks 15th in nation
- 56% of OHSU GME trainees stay in Oregon
  - Average nationwide is 45%
  - OHSU ranks 10th in nation
- Tend to settle close to where they train

Source: OHSU alumni questionnaires, AAMC

Oregon workforce relies on physician imports

- Despite very good retention, OHSU output is inadequate to meet demand
- Of the total number of licensed physicians in Oregon, 32% did all or part of their training at OHSU
- As national shortages worsen, Oregon will be competing for imported physicians

Source: OBME, 2006

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Changing our future

- Increase the “supply” of physicians opting to practice in Oregon
- Improve their geographic distribution
- HOW?
  - Create opportunities, advantages to stay in Oregon
  - Leverage resources
  - Enhance regional partnerships
- Oregon Medicine (ORMED) Collaborative

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Our strengths: ORMED

- Oregon Medicine Collaborative (ORMED)
- Unique partnership
  - OHSU
  - Oregon's higher education institutions
  - Regional health care systems
- Unique opportunity to build out regional capacity
- Enormous ancillary benefits to Oregon
  - Enhanced regional science programs
  - Academic presence in rural communities

The ORMED solution

- A three-step proposal:
  - Step 1: Regionalize and expand clerkships
  - Step 2: Increase class size (Medical Honors)
  - Step 3: Provide graduate training sites (*The GME Consortium)*
- Each step is essential

Step 1. Regionalize and expand clerkships

- Clinical clerkships are integral to OHSU unique medical curriculum
- Students introduced to state's providers
  - Encourages future practice in underserved areas
  - Enhances community partnerships
- Now, too few sites
- Training, accreditation, housing needed

Step 1: Regionalize and expand clerkships

- We cannot maintain or grow class size without new clinical sites
- Regional sites at Bend, Eugene already established for 120 students
- We are at risk of losing ground already gained! Funding is urgently required

We are at risk of losing ground already gained!

- Immediate Goal: Retain sites in Bend, Eugene
- Next year: Growth to Medford, Corvallis
  - Accommodate new students from Medical Honors program
- $1.2 - $1.5 million annual operating costs for all sites

Step 2: Increase the class size (Medical Honors)

- 25% of US medical schools offer combined undergrad/MD programs
- Program design by U of O, OSU, PSU (*in progress)*
- Design will play to strengths, goals of each institution
  - Accreditation by OHSU
  - Preferential Oregonian acceptance

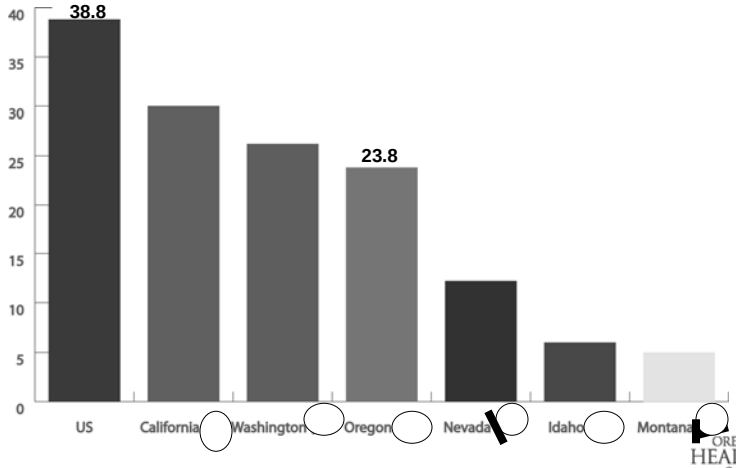
Step 2: Increase the class size (Medical Honors)

- Shortened time frame increases output
- Less student debt (average now is $155k)
- Rapid scale-up once established
- Needed clinical clerkships in place (Step 1)
- “Marquis” program for undergrad institutions
  - Enhances science programs
  - Keeps our best students IN OREGON
- Estimate of funding needed in progress

Step 3: Provide graduate training sites (The GME Consortium)

- As we grow number of graduates, must retain them in state
- *Train them in the communities where they are needed*
- Take advantage of opportunity presented by federal laws
- The GME Consortium: a framework for regional hospitals to establish training programs
  - OHSU manages/supports regional partners
  - OHSU is accrediting body

Residents and fellows (GME) in training per 100,000 (2005)



AMA Physician MasterFile, January 2005 (from AAMC)

Step 3: Provide graduate training sites (The GME Consortium)

- Complex federal regulations
- The 1996 regulatory "quirk" ensures underserved, regional focus
- Entails start-up costs ($400,000)
- But eventually, self-supporting from federal funds
- First steps:
  - Statewide needs assessment
  - Coordinate regional hospitals
  - Develop implementation/federal funding strategy

Step 3: Provide graduate training sites (The GME Consortium)

- High potential to address mal-distribution
- Case study: two OHSU family practice sites
- Since 1996
  - Klamath Falls: 81% (22 of 27) of the half retained in Oregon practice in rural/frontier regions
  - Portland: 18% (10 of 56) of the half retained in Oregon now practice in rural/frontier regions

Rural = a geographic area (county) 10 or more miles from a population center of 30,000; Frontier = a geographic area (county) with a population density of 6/sq mi or less (Office of Rural Health).

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Additional thoughts on primary care

- ORMED proposals provide framework to encourage new primary care in underserved areas
- Could be enhanced by other payer reforms:
  - Allow all providers to serve to the full extent of training
  - Focus on primary care teams
- Increase state support for a lower in-state tuition structure for Oregonian students at OHSU
- Tort reform/malpractice insurance

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Additional thoughts on primary care

- Loan forgiveness for “X” years in primary care?
- Rural areas paying student tuition?
- Important but neither ensures long-term commitments to rural/underserved areas
- Best solution: *Train them in the communities where they are needed*
- ORMED does that

What can you do?

- Health care reform must include aggressive investment in provider education
- Without clear support for provider education, health care reform will trade one access challenge for another
- Support ORMED initiatives
  - Increase educational capacity
  - Provide framework for primary care providers to stay in Oregon

Oregon Health Fund Board

"The Indian Health System"

Federal Laws Committee Meeting

Tuesday, April 22, 2008

1:00 – 5:00 pm

Jim Roberts, Policy Analyst
NW Portland Area Indian Health Board

Geoffrey Strommer, Attorney
Hobbs, Straus, Dean & Walker LLP

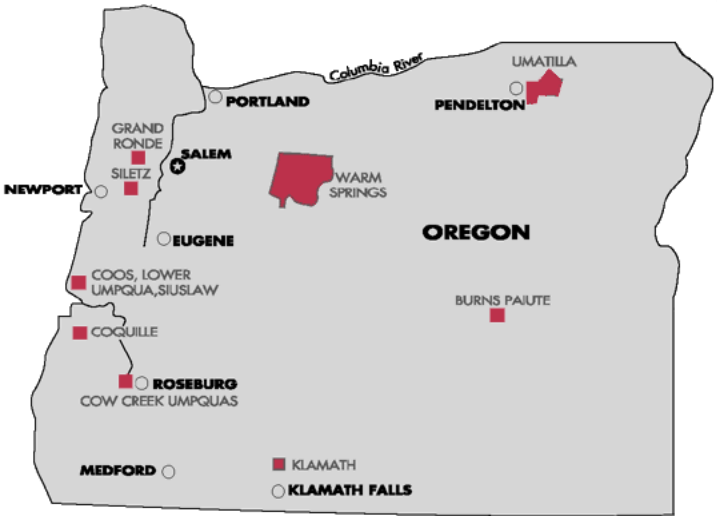
Presentation Overview

- Oregon Tribes – Indian Health System
- The Federal Trust Responsibility
- The Indian Health System
- Indian Health Disparities
- Guiding Principles for health reform & the Indian health system
- Unique circumstances of the Indian health system
- Discussion & Questions

Indian Health System - Oregon

- Nine federally recognized Tribes in Oregon
  1. Burns Paiute Tribe
  2. Coos, Siuslaw, and Lower Umpqua Tribes
  3. Coquille Tribe
  4. Cow Creek Band of Umpqua
  5. Grand Ronde Tribes
  6. Klamath Tribes
  7. Siletz Tribes
  8. Umatilla Tribes
  9. Warm Springs

Indian Health System - Oregon



Indian Health System - Oregon

- Tribal Health System provides care to
  - Tribal user population is 47,475
  - Urban Indian Program users 7,000
  - AI/AN population is 85,667 (2000 Census)
  - Provide services to AI/AN outside of Portland Area
  - Provide services to many non-beneficiaries

Why is Indian policy important to the OHFB?

- Charged with providing findings on impact of federal law requirements on achieving OHFB goals
- Most important federal programs for this discussion:
  - Medicare, Medicaid, and SCHIP
  - Benefits design/flexibility, access, and reimbursements
  - Medicaid Reform Roundtable with Urban Institute, Kaiser Family Foundation, and NASHP
- Oregon's policies can be precedent setting

Federal Trust Responsibility

Origins --

- U.S. Constitution
  - Indian Commerce Clause
  - Treaty Clause
  - Supremacy Clause
- Treaties, Executive Orders, Court Decisions
- Cession of over 400 million acres of land by tribes to the United States

Federal Trust Responsibility

- No single definition or context
- No bright-line parameters
- Encompasses political, social, economic interaction between Federal Government and Indian tribes

Federal Trust Responsibility

- Existence of Federal Trust responsibility is recognized in--
  - Court decisions
  - Laws
  - Regulations
  - Executive Orders; Presidential directives
  - Agency policy statements
  - Course of dealings with Indians
- Acknowledged by all branches of Federal Government

Federal Trust Responsibility

Judicial recognition of
Federal Trust Responsibility

Cherokee Nation v. Georgia (Sup. Ct. 1831)

- Described Indian tribes as "domestic dependent nations"
- Tribe-U.S. relationship "resembles that of a ward to his guardian"

Federal Trust Responsibility

U.S. v. Kagama (Sup. Ct. 1886)

- *"duty of protection" --*

"From their very weakness and helplessness, so largely due to the course of dealings of the federal government with [tribes], and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection]."

Federal Trust Responsibility

Morton v. Mancari (Sup. Ct. 1974)

- Established "rationally related" standard of review for Indian-specific laws
- Law will not be disturbed if rationally tied to Congress's "unique obligation" to Indians
- political rather than racial classification

Federal Trust Responsibility

Statutory recognition

- Snyder Act (1921)
  - permanent authorization of appropriations "for the benefit, care, and assistance of the Indians throughout the United States"
  - "conservation of health"
  - employment of physicians
  - recognized that U.S. has a responsibility to perform regarding Indians

Federal Trust Responsibility

- DOI Authority to contract with Private and Public entities to provide health care services to Indian people (1934)
- Transfer Act (1954)
  - transferred responsibility for Indian health from BIA to Dept. of HEW (now HHS)
  - objective: improve health care for Indians
  - creation of Indian Health Service

Federal Trust Responsibility

Self-Determination Era (1970's-today)

"[W]e have turned from the question of *whether* the Federal government has a responsibility to Indians to the question of *how* that responsibility can best be fulfilled."

President Nixon, 1970

Federal Trust Responsibility

- Themes of Nixon Message
  - recognized U.S. "solemn obligations" to Indians
  - U.S. must do better job at performing these obligations
  - involve Indians in --
    - policymaking
    - program operations

Federal Trust Responsibility

- Indian Self-Determination Act (1975)
  - Federal domination retards Indian progress
  - authority for tribal operation of programs
    - IHS and BIA directed to contract with tribes
  - preserved trust responsibility
  - amendments further enhanced tribal authorities
  - self-governance program (1987)

Federal Trust Responsibility

- Indian Health Care Improvement Act (1976)
  - Recognized health disparities in Indian Country
  - re-affirmed U.S. legal obligation for health care for Indian people
  - direction for delivery of health services
  - tribal involvement in health programs
  - reauthorization effort underway today

Federal Trust Responsibility

- Medicare, Medicaid
  - part of IHCIA (1976)
  - authority for IHS, tribes to collect M+M
  - increase Indian enrollment in M+M
  - improve Indian health facilities
  - 100% FMAP for Medicaid
    - U.S. obligation for Indian health

Federal Trust Responsibility

- Children's Health Insurance Program
  - enacted 1997
  - access for low-income Indian children
  - CMS bars cost-sharing for Indian children
    - unique federal relationship with Indian tribes
    - November 3, 2000 HCFA Tribal Leader Letter
    - October 6, 1999 SMD Letter

Federal Trust Responsibility

- Medicare Modernization Act (2003)
  - express access for IHS, tribal, urban Indian organization (I/T/U) pharmacies
    - authority for Secretary to issue standards to assure access
  - CMS requirements for Rx Drug Plans to offer network contracts to I/T/U pharmacies
  - Section 506 Medicare Like Rates for Contract Health Services

Federal Trust Responsibility

Presidential Policy Statements

- unique relationship with Indian tribes recognized by all recent Presidents
  - Executive Orders, Memoranda to agencies
- government-to-government relationship
- tribal consultation policies
  - DHHS
  - IHS
  - CMS

The Indian Health System

- IHS established in 1955 (after Transfer Act passed)
- Provides health care for 557 federally recognized tribes
- 1,139 health facilities in 35 different states
  - 49 hospitals, 545 health clinics, 231 ambulatory facilities, 133 health stations, 176 Alaska Native village clinics
  - 34 Urban Indian Health programs
- Divided into 12 administrative “Areas”
  - Portland Area Office (ID, OR, WA)
  - Portland Area has 43 tribes

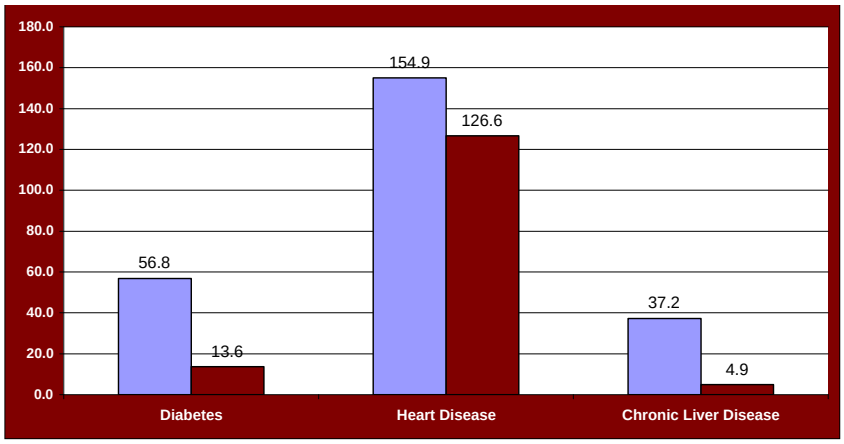
Indian Health Delivery System

- Indian Health Programs can be grouped into 3 categories:
  1. IHS Directly Operated
  2. Tribally Operated (P.L. 93-638)
  3. Urban Programs (34)

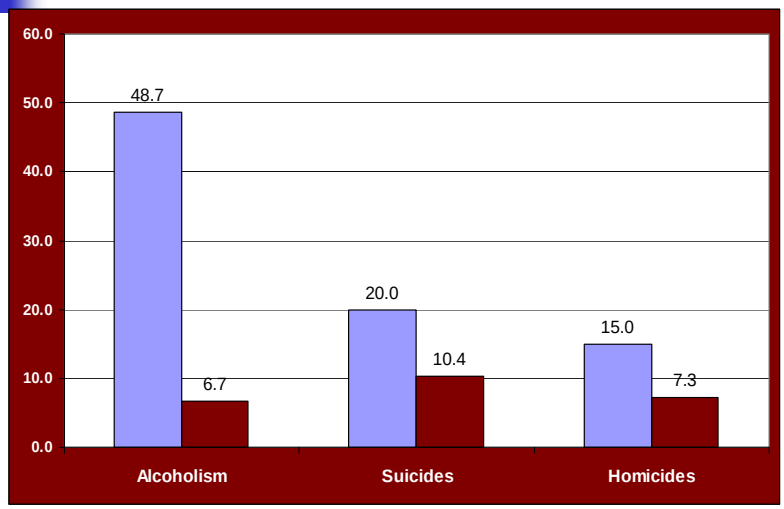
Indian Health System

- Types of Health Services
  - Ambulatory Primary Care (outpatient care)
  - Inpatient care - Hospitals
  - Medical specialties
  - Traditional healing practices
  - Dental and Vision Care
  - Behavioral health services
  - Specialty Care Services (CHS)

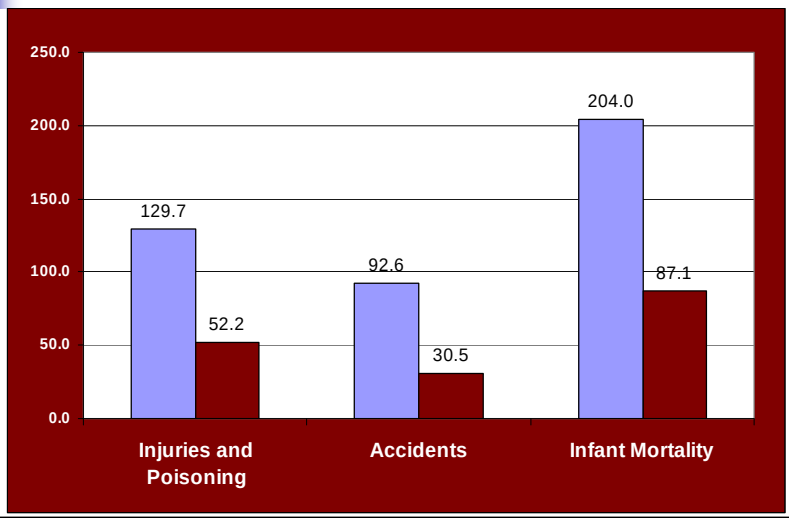
Indian Health System - Disparities Chronic Disease



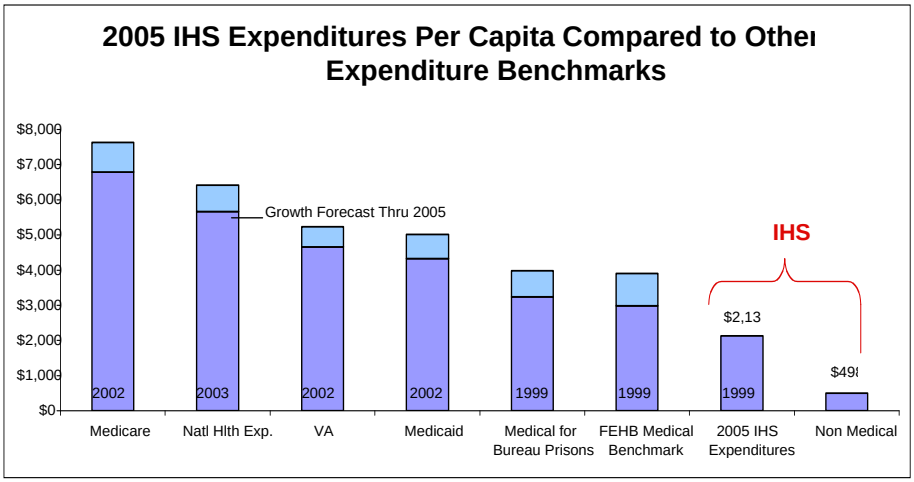
Indian Health System - Disparities Behavioral Health



Indian Health System - Disparities Preventative Health



Indian Health System – Disparities
Per capita funding



Indian Health System –
Medicaid Reform: Guiding Principles

- Federal Trust Responsibility
- 100% FMAP for Indian programs
- Cost-sharing: co-pays & premiums
- Benefits Design
- Managed Care Flexibility
- Access to program eligibility
- Cultural competent care & traditional practices

Indian Health System - Unique Circumstances

- Limited service population
- No cost assessed to patients
- Indian preference
- Only tribes get rights under ISDEAA
- Use of HHS personnel
- Unique health care providers
- Federal Tort Claims Act coverage
- Access to federal supplies
- See Barbero piece p. 71, “Legal Basis....”

Federal Trust Responsibility

Conclusion

- U.S. has obligation to --
  - "assure highest possible health status for Indians"
  - "provide all resources necessary“
  - When operating federal programs states share responsibility
- Trust responsibility for Indian health --
  - Justifies protection of Medicaid & SCHIP revenues for Indian health programs
  - Significant health disparities demands such protection

Questions/Discussion

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Federal Laws Committee

April 8, 2008

Jody Pettit, MD

Health Information Technology Coordinator

Office for Oregon Health Policy & Research

Project Director, Health Information Security & Privacy Collaboration

My understanding of the question at hand is: "Are there legal barriers in Federal Laws that Oregon must address to achieve our desired health care reform?" "Do we need to seek federal waivers?" Before I get started I want to give you a frame of reference and it is that I think my answers may not be what you expect. There are legal barriers but they may be different, even opposite of what you think they are.

The use of health information technology holds tremendous promise for improvement in the health and healthcare for Oregonians. The key concept to remember is, it's not about the technology – it's about the *information*. Information at the right time and place can make a profound difference in the safety, quality and efficiency of healthcare. As a practicing physician, I see patients without relevant pieces of their personal information practically every day in clinic. The Healthy Oregon Act recognizes the importance of health information technology in the following excerpt of the bill.

> *"Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable."*
>
> -- Senate Bill 329, 74th Legislative Assembly
>
> *The Healthy Oregon Act*

This is pioneering language is so many ways. Those 49 words envision a state that doesn't exist today. A personal electronic health record for every person that enables their health information to be available anywhere anytime it is needed for their care. That would be truly transformative and a very healthy move for Oregon. Another handful of the 49 words that is

ground-breaking is the phrase 'within the individual's control'. This suggests a significant shift in the way information is shared and makes this issue a 'handful' as well. We are on the forefront of this national discussion about patient's controlling their own information. The Oregon Health Record Bank project, a $5.5 million award to the Oregon Division of Medical Assistance Programs was listed as the #1 health IT project to watch by Input, a government health IT publication. Oregon is a focal point for this issue, eyes are on us to see how we handle these policies.

The HIPAA Privacy Rule doesn't present barriers to sharing information with it's 'covered entities' e.g. health systems, providers and insurers. But it does present barriers to '*provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.'*

The barriers I am referring to are as follows, there may be others:

1. Holders of health information are not required to share in an electronic format. Nor is it required to be standardized.

2. There is no legal framework to handle the concept of a 'personal health information custodian'.

3. There are problems with the HIPAA Privacy Rule that are slowing the progress toward health information exchange. One is a lack of enforcement of the rule and another is that the Rule doesn't protect people's privacy in the way that they expect.

To reiterate – the legal barriers are NOT to the sharing of information between healthcare entities like health systems, plan and providers but they are to the sharing and control of information by the patient.

We have learned much from the Oregon Health Information Security and Privacy Collaboration (HISPC), a federal subcontract involving 40 some states around the nation. Oregon is among the first set of states to join in this collaboration and has been involved now for a couple of years. The project examined privacy practices around the State, looked at Federal and State laws and made a set of recommendations which were presented to the Oregon Health Policy Commission. It has been moving forward on the consumer engagement portion of the plan because a major lesson was that consumers are not aware of how information flows in the current system.

One of the quickest ways to understand how the federal law regulates the flow of information is to read the Notice of Privacy Practices. It explains the use and disclosure of health information. Please note that State laws can layer additional protections on the HIPAA Privacy Rule. In addition there are categories of 'specially protected' information including HIV, sexually transmitted diseases, alcohol and drug use and mental health information.

The HIPAA Privacy Rule allows for information flow in the following manner: health information can be shared ***without the consent of the individual*** for purposes of Payment, Treatment and Operations (which includes business associates of the 'covered entities' under HIPAA. In addition, information can be shared for Appointment reminders, treatment alternatives, health-related benefits and services, fund-raising, directory information, with individuals involved in your care or payment for care. Health information can be disclosed for special purposes such as; coroners, medical examiners, funeral directors, disaster relief, health oversight activities, incidental disclosures, inmates, law enforcement, legal proceedings, military and veterans to military command authorities, organ and tissue donation, national security, intelligence activities, protection services for the President and others (to authorized federal officials for lawful intelligence, counterintelligence or other national security activities authorized by law, for protection of the US President, other authorized persons or foreign heads of state, ore for special authorized investigations) public health activities, research, as required by law, to avert a serious threat to health or safety and for worker's compensation.

A person has some rights with regard to their health information.

A person has a right to inspect and copy their medical and billing information, however this request may be denied.

A person has a right to amend their record, however that request may be denied.

A person has a right to an accounting of disclosures EXCEPT for: disclosures made for the purposes of treatment, payment or health care operations; disclosures you authorized, disclosures to you, incidental disclosures, disclosures from the facility directory, disclosures to family or other persons involved in your care, disclosures to correctional institutions and law enforcement in some circumstances, disclosures of limited data set information and disclosures for national security or intelligence purposes. Health oversight agencies and law enforcement may request that we temporarily suspend your right to a specific disclosure.

A person has a right to request restrictions, the covered entity is not required to comply with your request.

Right to request confidential communications, reasonable requests will be honored.

So ends the reading of the notice of privacy practices. The point of telling you all this is that in all likelihood there will be a policy shift during the tenure of the Health Fund Board. In fact, that policy shift is occurring in the form of the TRUST act – technologies for restoring users' security and trust in health information act. In addition, the Independent Health Record Trust Act.

In short, the current legal framework doesn't support this vision that Oregon has laid out.

Good Afternoon ladies and gentlemen, I am State Representative Ron Maurer serving House District 3 which includes most of Josephine County. I want to thank you for the opportunity to testify today on the subject of Federal Laws and more specifically, the Emergency Medical Treatment and Active Labor Act of 1986 or EMTALA.

But first I must explain my role in forming this conversation today. I participated in most of the late evening committee hearings during the 2007 legislative session. One specific area I suggested be included in Senate Bill 329 was the inclusion of a method of acknowledging the impact that federal law has on our ability to deliver healthcare and to transform healthcare into a more rational and sustainable system. I believe that as much as we all want to "fix" the problem we must admit that much is in the hands of the federal government and more specifically the health financing systems of Medicare and Medicaid. Any state's ability to transform healthcare is severely hampered by the federal government's stranglehold on the plurality of dollars expended for healthcare in this nation.

Locally, the Health Fund Board project is a noble effort but I reserve judgment on the recommendations forthcoming to the 2009 Legislative Assembly. My desire is that we begin to move the equation for the benefit of the consumer of medical and dental services rather than a further shift toward increasing government control. The illusion that success will be found in more regulation and more government is a doomed path indeed both practically and politically.

The healthcare delivery system we are troubled with today is a function of services we pay for. Essentially, healthcare providers and healthcare organizations provide those services that have a return on investment. It makes sense and we have a moral obligation to offer as many services as possible for the lowest cost possible but when any organization is required to offer services that are not reimbursable or are mandated through state and federal law to provide those services for free then there comes a point at which that organization ceases to exist and we all lose.

In my own clinic, a small, for-profit, federally designated rural health clinic, where my wife sees all the patients, she is available to them 24 hours per day, 7 days per week, 365 days per year, but she avoids routine telephone conversations with her patients and she does not e-mail her patients. Why? Primarily because we do not get paid for providing that kind of service. But, in our clinic we have one tool that emergency departments do not have. That tool is our ability to refuse to see patients who have no intention on paying for services rendered. Besides the moral obligation assumed by the typical emergency department, EMTALA requires that all who enter the doors of the ER shall be seen.

What has happened, as a result, in the last 20 or so years is a significant problem for the financial viability of many emergency departments. The problem of emergency departments continues to grow in both perception and in fact. According to the National Center for Health Statistics and the American Hospital Association, while the number of emergency department visits increased 18% to 110 million visits annually from 1994 to 2004 the U.S. lost 703 hospitals, 198,000 hospital beds, and 425 emergency departments.

The perception that the emergency department is the worst possible place receive primary care services let alone the most expensive place to receive non-urgent medical care drives much

of the debate about why we need to address this problem and part of this conversation today may be about seeking an EMTALA waiver and what would that mean.

Even though SB 329 does not specifically ask for the Health Fund Board to explore the "EMTALA Waiver" this concept was discussed in committee. Given that preliminary conversation I believe that receiving a federal waiver is a long shot. At several conferences since the end of the last Legislative Assembly I have specifically asked about an EMTALA waiver. With the "puppy dog tilt of the head" the answer both times has been, "they have never done that before and it is not going to happen". After reflection on the waiver question I believe the more compelling question is what can Oregon do in this realm to help itself? This question should be answered in the context of what the emergency department has become in light of its social obligation and the implementation of EMTALA?

Access to the emergency room has become a default public entitlement. The mere fact that this de facto public entity is an entitlement should afford those who provide services in this arena some protection from tort claims. It is inherently unfair and overtly illogical to demand that those we depend upon in an emergency bare the complete financial responsibility for the delivery of that very service the public does not just want but legally demands. Medical malpractice reform, even in the limited confines of the emergency department is truly under the purview of the state and changes could have a dramatic positive effect on healthcare delivery in Oregon. What I mean is that we in Oregon have control over our medical malpractice laws and, short of a total overhaul of medical malpractice laws, we can make a compelling case for capping non-economic damages for services provided in emergency rooms. Is this the final answer? No. But, it would be a significant first step.

One caution comes with this suggestion. No medical malpractice reform should be undertaken in Oregon through statutory change but must be constitutionally implemented by a vote of the people.

What this committee proposes and the array of solutions that the Health Fund Board brings to the 2009 Legislative Assembly will have significant impact on the healthcare reform debate over the next decade. It is my desire that we not forget the reality of the political debate that will ensue as a result of those recommendations and that we move toward a more rational and sustainable system of delivering healthcare to all Oregonians.

Respectfully Submitted,

Ron Maurer

Emergency Medical Treatment and Active Labor Act

Robert A. Lowe, MD, MPH
Director OHSU Center for Policy and Research in Emergency Medicine
Presentation to OHFB Federal Law Committee
April 8, 2008

Outline

- Historical context leading to EMTALA
- Will modifying EMTALA decrease costs and increase efficiency of Oregon's health care system?

Historical context of EMTALA

- Enacted in 1986
  - Emergency Medical Treatment and Active Labor Act
- Addressed financially-motivated transfer of unstable patients to county hospitals

Historical context of EMTALA

SPECIAL ARTICLE

TRANSFERS TO A PUBLIC HOSPITAL

A Prospective Study of 467 Patients

ROBERT L. SCHIFF, M.D., DAVID A. ANSELL, M.D., JAMES E. SCHLOSSER, M.D., AHAMED H. IDRIS, M.D., ANN MORRISON, M.D., AND STEVEN WHITMAN, PH.D.

Abstract In recent years there has been a dramatic increase in the number of patients transferred to public hospitals in the United States. We prospectively studied 467 medical and surgical patients who were transferred from the emergency departments of other hospitals in the Chicago area to Cook County Hospital and subsequently admitted.

Eighty-nine percent of the transferred patients were black or Hispanic, and 81 percent were unemployed. Most (87 percent) were transferred because they lacked adequate medical insurance. Only 6 percent of the patients had given written informed consent for transfer. Twenty-two percent required admission to an intensive care unit, usually within 24 hours of arrival. Twenty-four percent were in an unstable clinical condition at the transferring hospital. The proportion of transferred medical-service patients who died was 9.4 percent, which was significantly higher than the proportion of medical-service patients who were not transferred (3.8 percent, $P<0.01$). There was no significant difference in the proportion of deaths on the surgical service between patients who were transferred and those who were not (1.5 vs. 2.4 percent).

We conclude that patients are transferred to public hospitals predominantly for economic reasons, in spite of the fact that many of them are in an unstable condition at the time of transfer. (N Engl J Med 1986; 314:552-7.)

Emergency Department Patient 'Dumping': An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis, Tennessee

ARTHUR L. KELLERMANN, MD, MPH, AND BELA B. HACKMAN, MD

Abstract: To study the extent and nature of transfers of emergency department (ED) patients because of inability to pay, we audited all telephone requests and actual patient transfers from private hospital EDs and their affiliated free-standing emergency centers to the ED of the Regional Medical Center at Memphis (the Med), a publicly subsidized hospital, between June 1 and August 31, 1986. Transfers to the Med's "special care" centers were assumed to represent tertiary care referrals and were excluded. During the 92-day study interval, ED physicians at the Med handled 190 telephone requests for transfer. Requesting physicians explicitly identified "no money" or "no insurance" as the primary reason for transfer in 89 per cent of 164 cases in which these data were recorded. Thirty-seven per cent of requests were refused; half were too unstable or required an intensive care unit (ICU) bed when none were available. One hundred forty-six transfers (55 per cent) arrived without prior telephone authorization, most by private automobile. Almost all transferred patients (91 per cent) were sent for primarily economic reasons. One out of four was found to be unstable on arrival by explicit clinical criteria. Eighty-two patients transferred for economic reasons (34 per cent) required emergency hospitalization and accounted for 564 bed days during a period of extreme inpatient crowding. Three patients died prior to discharge. Two had been transferred for primarily economic reasons. (*Am J Public Health* 1988; 78:1287–1292.)

Special Communications

Patient Dumping

Status, Implications, and Policy Recommendations

David A. Ansell, MD, Robert L. Schiff, MD

recently documented at more than 40 public hospitals in Texas alone.[6] We define patient dumping as the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere. Common reasons for patient dumping include the absence of or insufficient medical insurance and the lack of an admission deposit. In addition, patients with "undesirable" conditions (such as intoxication or overdose conditions) may be the victims of patient dumping. In this article, we focus on the dumping of patients in need of emergency care.

spread problem. They contend that case reports of patient dumping are anecdotal and represent rare isolated incidents (*Long Beach Press-Telegram*, July 6-16, 1980).[2] The three largest transfer studies[1,6,7] suggest the opposite, ie, that patient dumping is a widespread, underrecognized problem that has become accepted and institutionalized in the United States. Extrapolating from data in available studies,[1,7] we estimate that 250 000 patients in need of emergency care annually are transferred for economic reasons.

Concerns have been expressed that

pensated care.[7] If the patients transferred to Cook County Hospital are representative of the patients transferred to public hospitals nationwide, the cost to public hospitals in the United States just of transferred patients requiring medical and surgical care would be $1.04 billion annually. This constitutes a direct shift of costs from the private health sector to financially troubled public hospitals. This $1.04 billion estimate of costs would be substantially higher if patients requiring pediatric, obstetric-gynecologic, and psychiatric care were included.

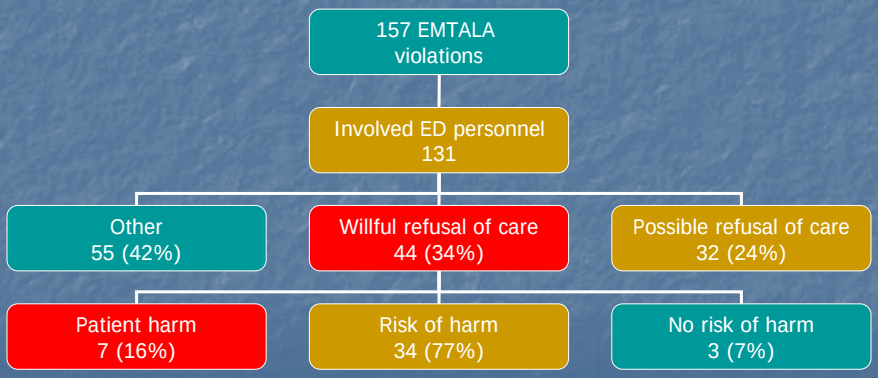
EMTALA

- Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals and physicians responsible for the following:
  - (a) negligently failing to appropriately screen an individual seeking medical care;
  - (b) negligently failing to provide stabilizing treatment to an individual with an emergency medical condition; or
  - (c) negligently transferring an individual in an inappropriate manner.

Is EMTALA still needed?

- Centers for Medicare and Medicaid Services
  - 294 confirmed EMTALA violations in 2000
- 157 records obtained through FOIA

EMTALA two decades later



Ballard, Amer J Emerg Med, 2006

Do we have to live with the risks of modifying EMTALA?

- Maybe, if doing so will decrease costs and increase efficiency
- Which assumes that much ED care is ...
  - Unnecessary
  - Expensive
  - Problem of personal responsibility & education

"Unnecessary" implies we can tell what's necessary

- 1990's: Managed care gatekeeping
  - Meningococcemia
  - Ruptured ectopic pregnancy
  - Massive vaginal bleeding → cardiac arrest
  - Ruptured duodenal ulcer

Young, Academic Emerg Med, 1997

"Unnecessary" implies we can *almost always* tell what's necessary

- Review of studies on patients triaged away from EDs
  - 0.25% - 1.9% same-day admission
  - ? Tip of iceberg?

Abbuhl, Academic Emerg Med, 1996

Are a few misses the price we have to pay?

- What are we saving?
- Is ED care expensive?

Impact of ED use on national health care costs is small

- As a proportion of US health care expenditures
  - 1.9% of national expenditures
  - 88% of ED expenditures are for insured patients
  - Half of uninsured costs are recovered from patients
  - → ED costs by the poor = 0.47% of US health care costs

- Tyrance, Amer J Public Health, 1996

Impact on hospital costs is small

- Providence Health Care System
  - ED costs ~ 5% of uncompensated care costs
  - Inpatient setting: the other 95% of costs

OHP savings from reducing ED use

- Optimistic scenario
  - Would only reduce total spending by 2%
- These savings might be offset
  - If patients delay care and are admitted for more expensive treatment
  - If patients use primary care setting instead
  - If they require more administrative overhead

- Handel, McConnell, Wallace and Gallia, 2007

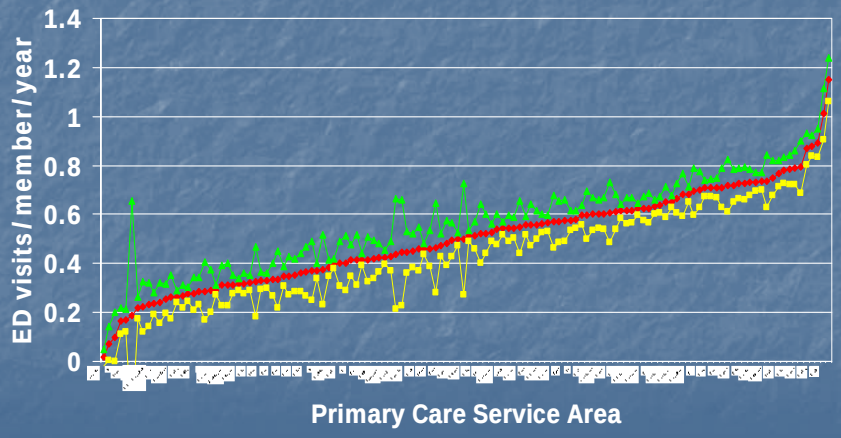
Oregon Division of Medical Assistance Programs

- “Attempts to eliminate ‘non-emergent’ ED utilization would cost DMAP more than they would save.”

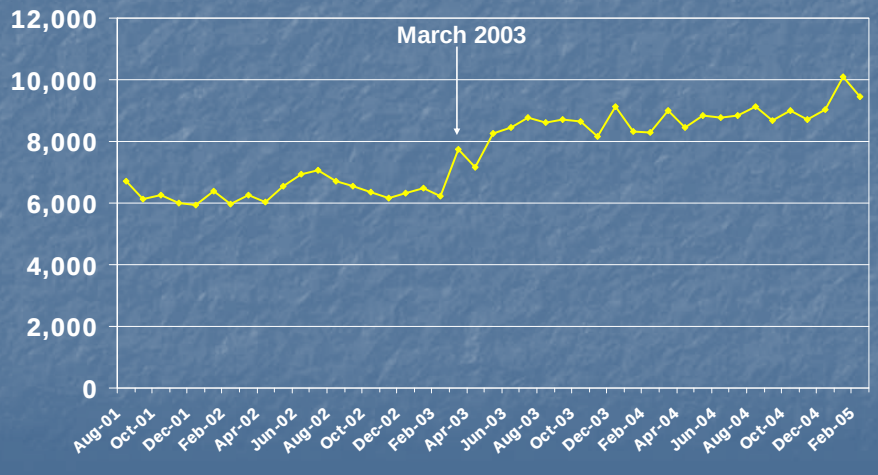
Is the “ED problem” a matter of personal responsibility?

- “But in my community…”
- “ER abusers”
  - Uneducated
  - Don’t pay (OHP)
  - Drug and alcohol users

ED use by OHP enrollees varies >10-fold in different Oregon Communities

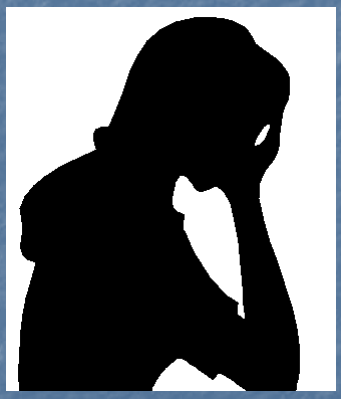


ED visits by uninsured rose from 6,441/month in 2002 to 8,754/month in 2004



21 Oregon EDs

Whom might we turn away?



- Allen and Ertz-Berger

Don’t fix what isn’t broken

- Modifying EMTALA
  - Risk to patients
  - Little financial benefit
- Real solution is improving access
  - Medical homes
  - Comprehensive care
  - Reduce hospitalizations

Oregon Health Fund Board
Federal Laws Committee
April 8, 2008

EMTALA: Emergency Medical Treatment and Labor Act

Hospital emergency departments are an integral part of the nation's health care safety net, staffed and equipped 24/7 to provide necessary unscheduled acute care for populations/regions. Care includes oversight of pre-hospital care providers, ED care, including resuscitation, stabilization, evaluation of acute problem(s), provision of necessary acute care and appropriate disposition: admission to hospital or discharge and referral for ongoing care.

ED utilization is increasing, mostly driven by the aging of population and increased demand for overall health services. Research has demonstrated that the EDs are one of most efficient providers of health care. Some episodic care provided to take advantage of 'stand-by' function/time. Urgent care costs similar to office setting. Charges absorb some stand-by, and uncompensated care costs. ACEP research has demonstrated uncompensated care provided by each emergency physician at over $140,000 per year.

Emergency physicians often are involved in health policy, using their experiences in the ED to provide first hand feedback regarding how policy decisions affect patient behavior and health as well as physicians' availability and ability to provide ongoing and consultative care.

There is general misunderstanding regarding patient's use of the ED for basic care. Research has shown some tendency of populations to seek care in EDs if provided insurance coverage but lacking access to ongoing care. The reality is that only about 12% of patients could have their care provided in less acute care setting, representing a very small portion of health care spending . In Oregon, during the 90's, patient deaths were attributed to active denial of covering costs of ED care and overzealous gate-keeping by capitated health plans.

Unfortunately, over time most patients lacking coverage or in areas with health provider shortages, avoid health care altogether. Some then arrive at ED with an acute health crisis.

It is the potential avoidance of the cost of this acute care crisis and hospitalization which can represent improved health and opportunities for financial savings to populations if provision is made for access to primary care including insurance coverage and an adequate workforce.

EMTALA legislation was passed in 1986 to protect patients from discrimination for financial reasons, including the transfer of women in active labor, trauma and unstable patients in need of emergency care prior to appropriate stabilization. The focus of the regulations is on evaluation (the medical screening exam), stabilization and disposition based on medical need.

Many investigations in Oregon for alleged ‘patient dumping’ shortly after legislation enacted. Number of complaints has markedly decreased over the years resulting from education and awareness of potential fines and penalties. Some tendency by trial lawyers to shift medical malpractice claims to include EMTALA violation and thereby gain access to federal courts, avoiding limitations which might exist in local jurisdictions.

EDs in Oregon as across the country are seeing pressure from increased demand, increasing population with decreased number of hospitals, decreased health care coverage, decreased access to primary and ongoing care (caused by workforce shortage and decreasing reimbursement).

This has resulted in crowding and diversion issues which are high priority issues for many medical societies including the American College of Emergency Physicians, Oregon College of Emergency Physicians and the Oregon Medical Association. Recent ‘calls for action’ have highlighted difficulties in providing care for psychiatric patients. EDs are challenged to provide ongoing necessary acute care let alone expanding capacity to meet needs in disaster situations.

Solutions for ED crowding are being pursued at national and state processes aimed at increasing coverage for entire population and expanding the healthcare workforce to provide access to primary and ongoing care.

Compliance with EMTALA regulations is required for any hospital providing emergency services wishing to participate in Medicare program and is regulated by both CMS and the OIG. Federal CMS task forces and IOM have reviewed EMTALA and recommended incremental changes in regulations but preservation of original goals. Any proposed change not consistent with original intent of legislation would place vulnerable patients at risk.

John Moorhead MD MSFACEP
Board of Directors, Oregon College of Emergency Physicians

Difficulties in Managing Rural Mental Health Patients

Current Mental Holds

Two Professional Hold (72 hour)

- Must be on the agreement of two Physicians or a Physician and a Mental Health Professional.
- Can only be used by a "Psychiatric Receiving Facility".
- Patient must be released or have a sanity hearing in 3 days.

Transfer Hold (12 Hour)

- Initiated by a single physician, used to transport patient securely to a 'Psychiatric Receiving Facility".
- Can only be used by by a facility approved by DHS. (OAR309-033-0200 through 309-033-0740
- Good for only 12 hours.

Police Hold

- Only until patient is evaluated by physician.

(In all holds the patient must be deemed a danger to themselves or others or unable to care for themselves.)

So What's The Problem?

Rural Emergency Department Physicians cannot hold dangerous psychiatric patients against their will.

Examples of the Problem

1. Sky Lakes Hospital, Klamath Falls
   - ER doc says patient is suicidal, KCMH says no, lets patient go, ER doc cannot put patient on a hold.
   - Patient returns in 2 days, stabbed himself in neck. ER doc says suicidal. Admitted to ICU, on call psychiatrist releases him same day.
   - Patient returns in a week, DOA, shot himself in the head
2. Sky Lakes
   - Patient OD's on medication, ER doctor says suicidal, KCMH disagrees, sent home.
   - Returns next day with another attempt, released by KCMH.
   - Attempts again following day, transferred to psychiatric facility.

More Examples

- Ashland Community Hospital, Ashland
  - Patient is psychotic, but won't stay in ER. Doctor can't hold patient, so calls police and follows patient out of ER through Ashland until police arrive to place a hold.
- Ashland
  - Sick suicidal patient walks out of ICU, assumed left AMA, can't be put on a hold.
  - Found 2 days later in a dumpster at the dump.
- Ashland
  - ER doctor wants psychotic patient transferred to psychiatric facility, JCMH disagrees, patient found wandering naked in snow the next day.

Is There a Conflict of Interest?

County Mental Health agencies have to PAY for an expensive secure transport to a psychiatric facility if they put a patient on a hold. That means less money in their budget.

What About EMTALA?

EMTALA says we cannot release a medically unstable patient unless we don't have the means to stabilize, and then only to a higher level hospital. This is designed to protect the patient.

Are these psychiatric patients medically unstable? Yes!

The Dilemma

EMTALA rightly says we can't release an unstable patient, but DHS will not allow us to legally hold a psychiatric patient in a non-psychiatric hospital.

DHS and EMTALA are at odds

In a Nutshell

ER Doctors in rural hospitals are unable to legally hold psychiatric patients against their will.

(This position reaffirmed by QI and Certification Manager for Licensing and Certification for Mental Health, DHS Oregon)

The Solution

There are several ways to solve the problem:

1. Have DHS or the Attorney General re-interpret their regulations to comply with Federal law.
2. Change Oregon law to address these problems in rural Oregon.
3. Others?

Presentation to

OHFB Federal Laws Committee

March 25, 2008

John A. Kitzhaber, M.D.

Creating a Framework for Change

- **The Wellness System**
- **The Medical System**
- **Financing and the Economic Model**

Health Care Cost

1965-1975 – Medical inflation grew 18% faster than CPI
1995-2005 – Medical inflation grew 50% faster than CPI

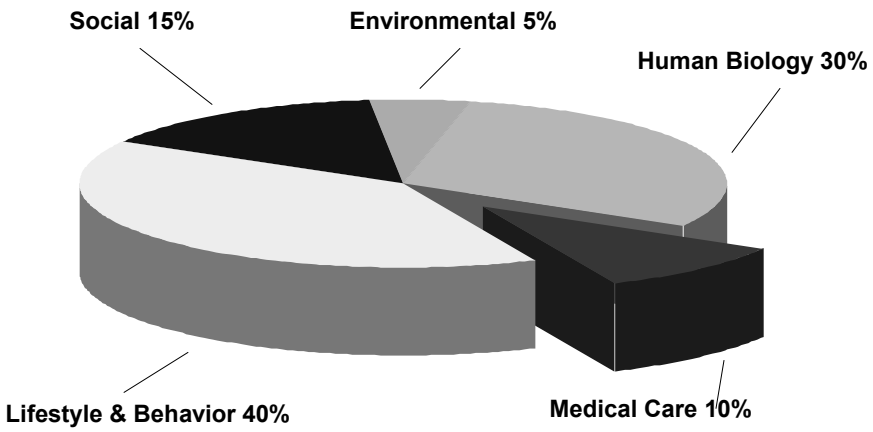
2004 = 8% of all federal income tax went to Medicare
2015 = 19% of all federal income tax will go to Medicare
2025 = 32% of all federal income tax will go to Medicare

Health Outcomes

Health care is a means to an end … not an end in itself

	1960	2007
Infant Mortality	12th	44th
Life Expectancy	16th	36th
U.S. % GDP on Health Care	6%	17%

Health Field Model
Influence Factors on Health Status



Source: McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs, 21(2),* 83

Chronic Disease*

People with chronic diseases → 70% HC spending

- **Diabetes**
- **Coronary Artery Disease**
- **Congestive Heart Failure**
- **Asthma**
- **Depression**

*George Halvorson Health Care Reform Now

Distribution of Health Care Expenditures*

1% of population ⟶ 35% of HC spending

5% of population ⟶ 60% of HC spending

10% of population ⟶ 70% of HC spending

*George Halvorson Health Care Reform Now

Lifestyle

Lifestyle choices (e.g. diet, exercise, smoking) contribute significantly to the development of chronic disease.

<u>Lifestyle contributes</u>:

- **90% to diabetes**
- **80% to heart disease**
- **70% to cancer**

Managing Chronic Disease*

These diseases are progressive.

We know how to intervene to <u>prevent</u> complications.

<u>Requires</u>

- **Care team to coordinate care and share information**
- **Well educated patients who can recognize early warning signs of a complication**
- **Rapid response**
- **Doing the right thing at the right time very quickly**

****George Halvorson <u>Health Care Reform Now</u>***

Our system was not designed to:

- Prevent illness
- Manage chronic conditions

The demands on the system have changed but the system itself has not evolved to meet those changes.

Evolution of the System

- Acute care “infectious disease” model
- Conditions that were once fatal become chronic
- Solo or small group practices working independently
- Lack of Data

Most people with chronic conditions

- Interact with the care system only in crisis
- Get the appropriate care only 50% of the time

Financial Incentives*

Financial incentives reward acute care interventions and discourage reorganization around chronic care management.

<u>9,000 individual billing codes</u>

- **No code for a cure**
- **No billing code for prevention**
- **No billing code for health improvement**

… These are not billable events

**George Halvorson <u>Health Care Reform Now</u>*

Billable Revenue*

Preventing CHF → $200 billable revenue

Allowing CHF crisis → $10,000 - $20,000 billable revenue

Preventing an asthma attack → $100 billable revenue

Treatment in ER → $2,000 - $4,000 billable revenue

Treatment in hospital → $10,000 to $40,000 billable revenue

**George Halvorson <u>Health Care Reform Now</u>*

Transformational Change

Agreeing on a Vision

What is the Purpose of our Health Care System?

Triple Aim
(Institute for Healthcare Improvement)

1. **Improve population health**
2. **Reduce per capita cost**
3. **Improve patient experience**
   - **Outcomes**
   - **Safety**
   - **Satisfaction**

Economic Stakeholders

- Uninsured
- Workers with good employer-sponsored coverage
- Seniors on Medicare
- Those with disabilities and other special needs
- Employers
- Doctors, hospitals and other providers
- Insurers and health plans
- Pharmaceutical manufacturers
- Medical device manufacturers
- Others…

Political & Economic Realities of Current System

Millions of jobs depend on current structure
- 1:11 jobs in U.S. in the health care sector
- 1:7 dollars in our economy is related to health care.

… Nobody wants to lose their job

16% of Americans have no health insurance
- 84% do have health insurance

…They are not going to give it up

There is a lot of trapped equity in the current system
- Bricks and mortar
- Technology
- Reimbursement structure

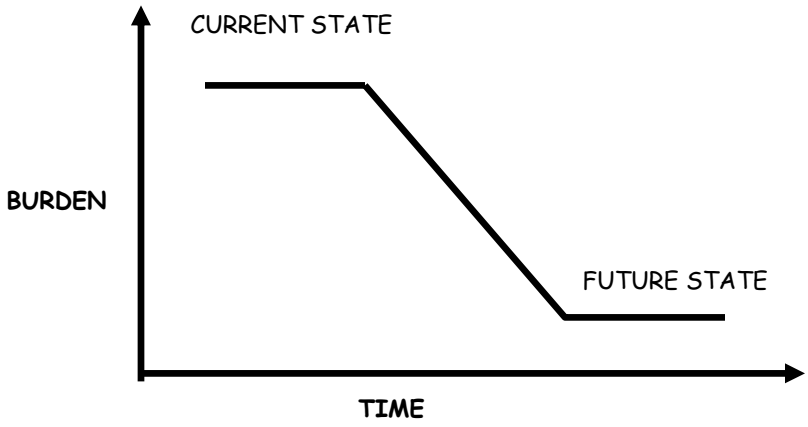
…Nobody is going to walk away from that

Transition

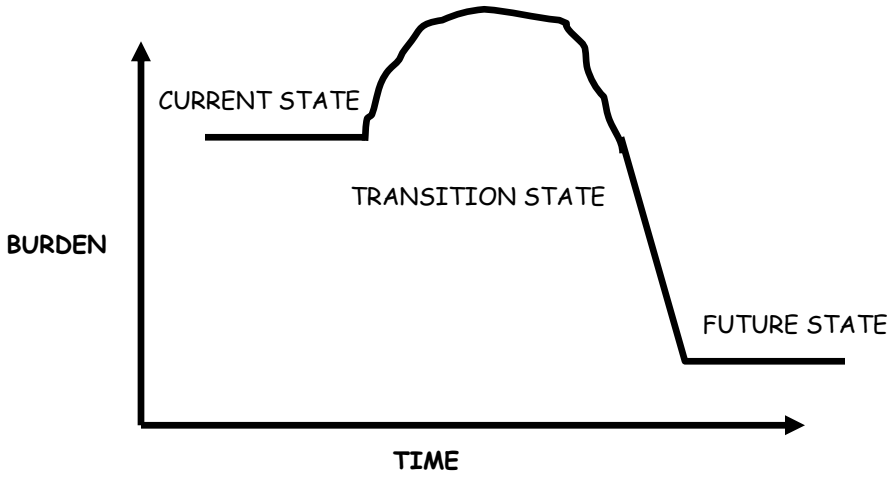
It is politically and economically impossible to move from current system to a new system overnight.

There must be a transition period.

The Future State – Most Can Be Winners *(D. Berwick, M.D., IHI)*



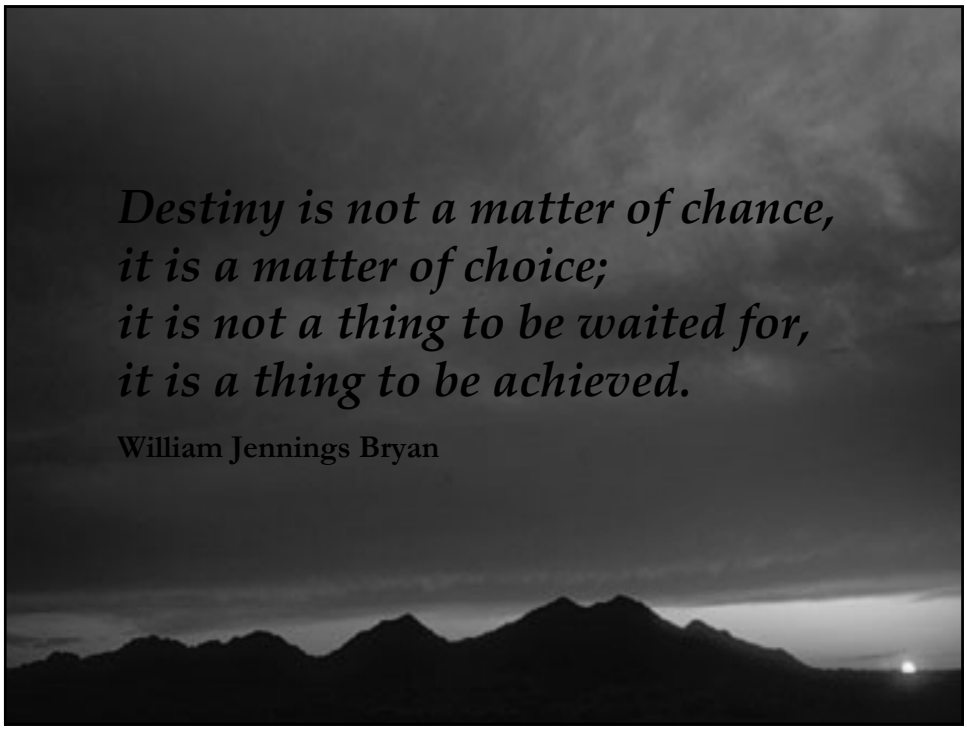
The Transition State – Hard for All *(D.Berwick, MD., IHI)*



Agreeing on a Shared Vision

Without first agreeing on where we want to end up there is no political pathway by which to get there.

Leadership Starts with Us



Clear Choice Health Plans Medicare Advantage

Federal Laws Committee

March 13, 2008

Patricia Gibford, President & CEO

Overview

- Rural Focus
- First PSO Medicare+Choice Contract 1998- Medicare Advantage
- Oregon Service Area 12,000 lives or 27%
  - Crook, Deschutes, Jefferson, Harney, Grant, Wasco, Hood River, Sherman , Wheeler & some northern zip codes in Lake & Klamath Co.
- Western Montana Service area
  - Flathead, Missoula, Lake & Lincoln Counties

Provider Networks

- Oregon
  - 98% physicians 650 +/-
  - 100% hospitals 9

  Western Montana 470 +/-
  - Northwest Montana Physicians Association 140
  - Individual provider contracts 340 +/-
  - Hospitals
    - Kalispell Regional Medical Center, Heath Center NW
    - St. Josephs - Polson
    - St. Patrick's - Missoula

Current Issues

- Lack of understanding regarding MA plans contribution, value added
- Reimbursement (floor counties)
- Access (PCP)
- Provider reimbursement & self referral
- Increasing costs
- Increasing utilization
- Higher MLRs

Federal Policy Issues

- No political clout in DC
- Access not seen as a “big” issue by Med Pac
- Healthcare reform & universal coverage
- PFFS & PDPs lack of controls
- Negative Spillover
- Retroactive disenrollment

Issues

- Changes without testing
- Constant “fixes”
- HHS $250 billion in budget cuts
- Baby Boomers
- Unsustainable system
- Ethics of Limits
- It is all about the money!

CareOregon Advantage

Oregon Health Fund Board

Federal Laws Committee
March 13, 2008

Patrick Curran, Medicare Director

Overview of Special Needs Plans (SNPs)

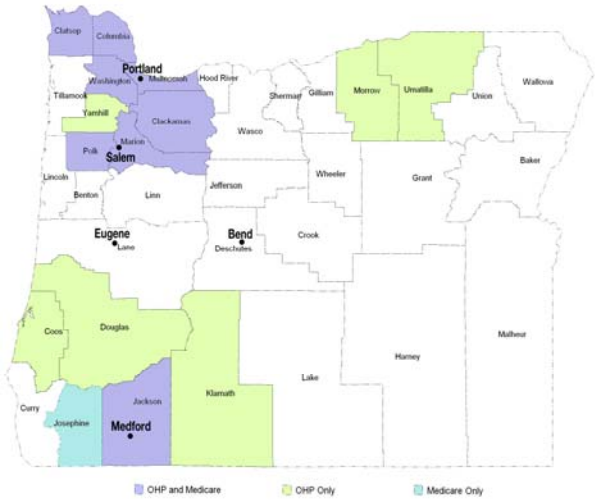
- MMA allowed SNPs to target Medicare clients:
  - ✓Dually eligible (310*)
  - ✓Institutional (85*)
  - ✓Chronic conditions (74*)
- What's so special?

*Number of plans in 2007

CareOregon Advantage

CareOregon Advantage

- **5,300 SNP members in 9 counties**
- **All fully dual eligible**
- **>60% of members under age 65**
- **40% of enrollment with Community Health Centers**
- **Access mental health through community mental health centers**



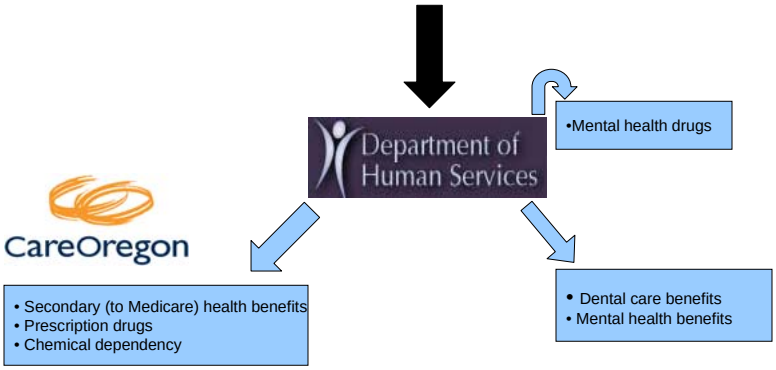
CareOregon Advantage

Integration with the State of Oregon

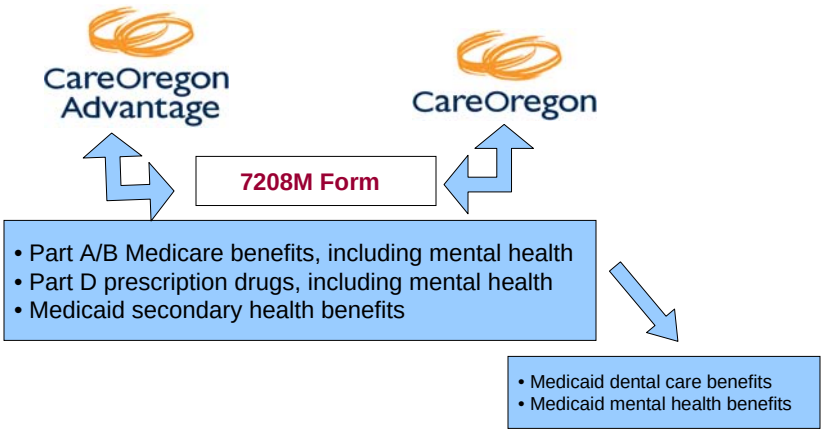
CareOregon Advantage

Medicare/Medicaid services for duals prior to SNP

Medicare Parts A/B - primary



Medicare/Medicaid services for duals after SNP



The benefits of integration

OHP eligibility

Community resources

OHP benefits

Access to care

Care coordination

Extra benefits

OHP appeals

Part D Drug benefits

Parts A/B Benefits

Medicare appeals

CareOregon Advantage

On FFS reimbursement

Visit to primary care physician

↓

Medicare FFS payment of 80%

↓

OHP FFS coordinates benefits

↓

Clinic cannot bill client

CareOregon Advantage

Questions

Patrick Curran
Medicare Director
CareOregon
503-416-1421
curranp@careoregon.org

CareOregon Advantage

Special Needs Plans (SNPs) – 3 types

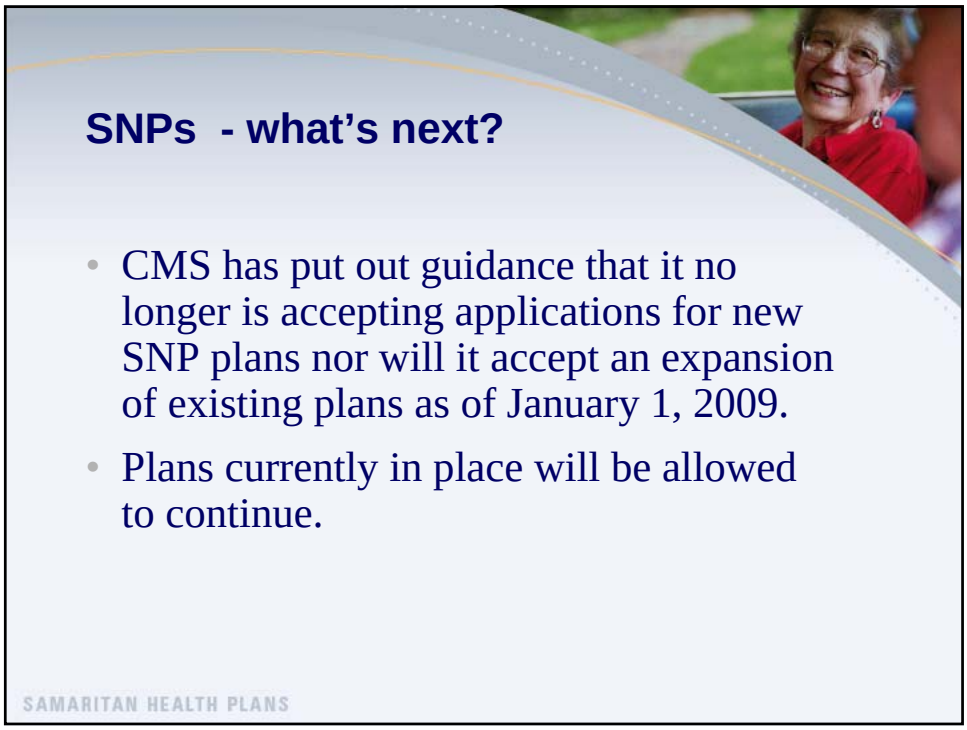
- **Institutional Plans -** Those who reside or are expected to reside for 90 days or longer in a long term care facility (defined as either: skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility).
- **Dually Eligible Plans -** Entitled to medical assistance under a State plan under Title XIX. SNPs may enroll all dual eligible beneficiaries, such as the full duals only, and zero cost sharing duals (QMB only and QMB pluses). In addition, if a dual eligible plan contracts with a state for a Medicaid wrap, then the plan can further subset, for example, full duals with mental illness or duals over 65 years old.
- **Chronic Condition Plans -** CMS did not set forth detailed definition of this in the regulation in order to provide industry as much flexibility as the law allows for this type of MA SNP, and to provide an opportunity for CMS to gain experience which may lead to future refinements.

SAMARITAN HEALTH PLANS

SNPs – Value added

- SNPs are allowed to target special clinical programs to address distinct health care needs
- Dually eligible SNPs can help to address enrollment challenges
- Institutional SNPs can create plan designs specific to inpatient challenges
- Chronic Care SNPs can focus on identified chronic care conditions to address. Chronic Care SNPs are broader in their definition allowing plans flexibility and allowing CMS to gain experience in this area.

SAMARITAN HEALTH PLANS



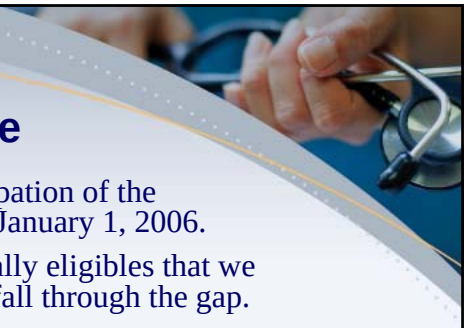
SNPs - what's next?

- CMS has put out guidance that it no longer is accepting applications for new SNP plans nor will it accept an expansion of existing plans as of January 1, 2009.
- Plans currently in place will be allowed to continue.

SAMARITAN HEALTH PLANS


Benefit of Dually eligible SNPs
• Addressing administrative challenges
• Increased opportunities for targeted enrollment for plans that develop a relationship with the State
• Increasing State awareness of how to effectively contract with SNPs
• Improved Quality Measure for SNPs
SAMARITAN HEALTH PLANS


Samaritan Advantage Health Plan (SAHP) ~ SNP
SAMARITAN HEALTH PLANS



Samaritan Advantage

- Started June 1, 2005 in anticipation of the implementation of Part D on January 1, 2006.
- Samaritan IHN had 1,600 dually eligibles that we wanted to make sure did not fall through the gap.
- Coordinated effort with DMAP to enroll dually eligibles onto our plan due to state law.
- Considerable coordination happened and the transition went smoothly for our members
- Continuity of Care was enhanced due the fact that we already knew the members and had been working with them as their secondary payer prior to starting SAHP. We had an increased knowledge of their needs and utilization and were able to make the transition seamless.

SAMARITAN HEALTH PLANS

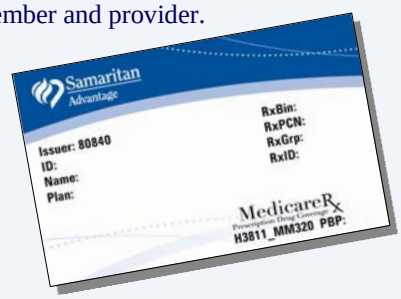
Samaritan Advantage con't…

- Samaritan Advantage, as a community based plan, allows us to continue to enhance the way we are able to take care of those who live in the communities we serve.
- Access is guaranteed due to contractual agreements with providers. Some providers no longer take original Medicare. By contracting with us we guarantee access through our contractual arrangements.
- Medicare Advantage Plans, like Samaritan Advantage, are set up in a capitated model that allows plans to offer a slightly higher reimbursement than traditional Medicare as our rates are based on an agreed upon Bid. The Bid is based off of historical utilization and costs related to the members on our plan. This gives the plans more flexibility in their contracting and provides CMS more stability in its budgeting.

SAMARITAN HEALTH PLANS

Benefits of SAHP- SNP

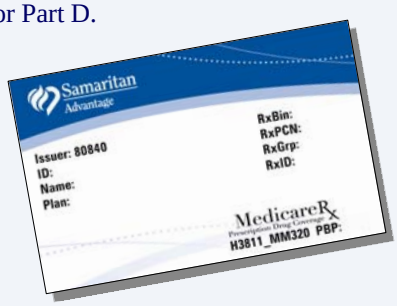
1. Provider sends one claim and Samaritan Advantage pays primary and then transfers it to IHN to pay secondary. No additional bill needs to be sent.
2. Prescription coverage is processed through the same Pharmacy Benefit Manager (PBM) and done at Point of Sale making the payment for prescriptions seamless for the member.
3. Mental Health Benefits are coordinated for both authorizations and payment making it easier on the member and provider.
4. One Case Manager or ENCC is managing the members care and coordinating with the providers.



SAMARITAN HEALTH PLANS

Benefits of SAHP- SNP con't…

5. Coordinated process for Prior Authorizations between Samaritan IHN and SAHP allows less work for the providers and the members.
6. Coordinated approach to Quality Improvement programs and Performance Improvement Programs.
7. Appeals and Grievance process available to members is clearly defined and monitored by the CMS Regional Offices for Parts A&B and the CMS Central office for Part D.



SAMARITAN HEALTH PLANS


Questions?
Samaritan
Health Plans
Building healthier communities together

MA Enrollment in PFFS, HMO, PPO by Congressional District, Jan 2008

County	PFFS	HMO	PPO	Total	% in PFFS
Congressional District 1: NW Oregon, North/West of Portland					
Clatsop	183	323	273	779	23.49%
Columbia	556	1,789	1,187	3,532	15.74%
Washington	1,453	17,181	5,773	24,407	5.95%
Yamhill	204	2,395	2,892	5,491	3.72%
Subtotal:	***2,396***	***21,688***	***10,125***	***34,209***	***7.00%***
Congressional District 2: Eastern Oregon					
Wallowa	130			130	100.00%
Malheur	752		18	770	97.66%
Baker	502		16	518	96.91%
Union	779		36	815	95.58%
Harney	78		15	93	83.87%
Umatilla	1,317	400	58	1,775	74.20%
Klamath	1,931	749	50	2,730	70.73%
Morrow	131	56		187	70.05%
Lake	105	71		176	59.66%
Hood River	350	340	71	761	45.99%
Sherman	52	62		114	45.61%
Wasco	333	635	20	988	33.70%
Crook	272	760	35	1,067	25.49%
Wheeler	22	68		90	24.44%
Grant	105	352		457	22.98%
Jefferson	81	1,033	13	1,127	7.19%
Jackson	520	359	6,427	7,306	7.12%
Deschutes	334	7,491	88	7,913	4.22%
Subtotal:	***7,794***	***12,376***	***6,847***	***27,017***	***28.85%***
Congressional District 3: Portland/Clackamas					
Clackamas (Also District 5)	1,328	17,938	6,989	26,255	5.06%
Multnomah	1,895	33,405	8,129	43,429	4.36%
Subtotal:	***3,223***	***51,343***	***15,118***	***69,684***	***4.63%***
Congressional District 4: Western and Southwestern Oregon					
Curry	287	36	23	346	82.95%
Douglas	1,559	1,933	123	3,615	43.13%
Coos	613	1,230	76	1,919	31.94%
Josephine	191	1,904	2,999	5,094	3.75%
Benton	133	3,251	610	3,994	3.33%
Lane	409	9,270	9,535	19,214	2.13%
Linn	84	4,829	3,084	7,997	1.05%
Subtotal:	***3,276***	***22,453***	***16,450***	***42,179***	***7.77%***
Congressional District 5: NW Oregon, South/West of Portland					
Tillamook	180	63	68	311	57.88%
Lincoln	509	696	104	1,309	38.88%
Marion	1,588	13,882	8,179	23,649	6.71%
Polk	374	3,088	2,457	5,919	6.32%
Clackamas (also District 3)	1,328	17,938	6,989	26,255	5.06%
Subtotal:	***3,979***	***35,667***	***17,797***	***57,443***	***6.93%***
TOTAL	**19,340**	**125,589**	**59,348**	**204,277**	***9.47%***

http://www.cms.hhs.gov/MCRAdvPartDEnrolData/

Oregon Health Fund Board – Federal Laws Committee
Testimony of Chandran "Chad" Cheriel, PhD, AARP Oregon Executive Council Volunteer
RE: Medicare
February 28, 2008

Good morning, Chair Baumeister, Vice Chair Gradison and Committee members. I am here today as a member of AARP, a volunteer with the state office's Executive Council which helps determine AARP Oregon's strategic direction. Having been involved in health policy discussions over the past 30 years, I've long stressed the need for health reform to ensure access to affordable, quality care for everyone. Over those years, I also have been active in promoting cost control and prevention as key ingredients in transforming our health care system.

We are all acutely aware of the need for reform in many key sectors of our health system. AARP has partnered with and supported a variety of state and national initiatives designed to improve health care access, quality and control costs. "Divided We Fail" is a bold initiative undertaken with the support of a number of businesses and labor organizations. This initiative, we hope, will help "break the gridlock" and create the space and opportunity to develop a more rational and sustainable health reform for our country.

With reference to your committee's work, I will limit my comments to the following issues:

- Cost controls, prevention and care coordination practices should play a central role in the development of sustainable financing options;
- Medicare recipients and providers would benefit in terms of quality and program sustainability from implementing programs of care coordination, prevention and the elimination of inefficiencies in the health care financing and delivery system; and
- The real challenges to our health care system are the unsustainable rising costs overall. Medicare has not caused this crisis, but rather reflects its symptoms. Medicare is not perfect by any means, but it:
    - Has dramatically increased access to health care for seniors, and helped keep many seniors from impoverishment due to health conditions;
    - Has, in conjunction with Social Security, pulled half of the nation's seniors out of poverty.

- Operates with lower administrative costs and has developed innovative cost-control measures, many adopted by the private sector;
- Has kept pace with new technologies, added many key preventive services to detect and treat medical problems early, has led to improved quality of care, and has ensured greater transparency and consumer protections;
- Enjoys generally deep satisfaction from those it serves and allows patients to choose their doctors and other providers; and
- Has offered portability, giving seniors everywhere security in their health coverage, including issues of benefit and enrollment.

- Specific to Medicare's relatively recent addition of Part D prescription coverage, this has been a tremendous positive step to improving access to affordable medications. However, there is much room for improvement here too. Besides helping low-income beneficiaries by raising asset limits, the federal government should take a valuable lesson from Oregon's playbook with the Oregon Prescription Drug Program and its bulk negotiating power and authority to save significant dollars.

There are a few other key areas where Medicare dramatically impacts Oregon and its health care structure and reform efforts, especially in the area of reimbursements. Kirsten Sloan, AARP's federal affairs lead on health issues in Washington, D.C., will help address those areas and more about Medicare in just a moment.

Thank you again for your time and consideration today, and also for your dedication and service in helping fix our state's health care system.

Reflections and Recommendations on Health Care Reform

Governor's Commission on Senior Services

Presented to OHFA Federal Laws Committee 2/28/08 by:

- *Charles Frazier*
- *Robert Lawrence*
- *Peggie Beck*

The State of Things Today

1. Decreasing Access to PCPs

- *Nearly ¼ of Oregon physicians have closed their practices to new Medicare patients:*
  - *Psychiatry 51.1% closed 12.5% limited*
  - *Internal Medicine 25.3% closed 11.4% limited*
  - *General Practice 25.4% closed 20.6% limited*

1. Decreasing Access to PCPs

Reasons:

- *Low reimbursement rates*
- *Medicare/Medicaid rules and procedures*
- *Managed care rules/prior approval needs*
- *Insurance Paperwork/Bill*
- *Other*

RECOMMENDATIONS:

- *Increase reimbursement rates for PCPs*
- *Recognize cost of doing business today -*
  -or-
  - *Consider balance billing waiver*
- *Consider "Concierge Care" programs by PCPs*

2. Other Implications of Lack of Access

- *Patients delaying care, increasing system costs*
- *Lack of advocacy for patients, less likelihood of individuals following good health practices*

RECOMMENDATIONS:

- *Encourage that Medicare/Medicaid Patients have a PCP*
- *Make clear to PCPs that their role includes patient advocacy and education*

3. Patient-Directed Care

- *Patient-Directed Care has received a lot of attention*
- *Some proposals suggest Americans shop for health care—may not be realistic:*
  - *Patients don't know the costs of care*
  - *Billing systems are hard to read*
  - *Billing and payment systems often very slow*
  - *Patients' ability to catch errors limited*

RECOMMENDATIONS:

- *Mandate a clear and timely medical billing system*
- *Require specific information on bills*
- *Find ways to stop drawn-out adjudication process*

4. Poor Utilization of Information Technology (IT)

- *Many sectors of health care industry are slow to apply IT*
- *Patients and providers should expect information to flow*
  - *Seamlessly*
  - *Confidentially*

RECOMMENDATION:

- *Provide incentives to accelerate the application of IT to the entire health care industry*

5. Need for Liability Reform

- *Providers must practice in very litigious society*
- *Practice of defensive medicine adds to costs of health care*

RECOMMENDATION:

- *Support revision of tort laws to reduce:*
  - *Frivolous lawsuits*
  - *Excessive jury awards*

  ... which lead to "defensive medicine" by practitioners.

6. Avoiding Waste and Duplication

- *There is infinite need and finite resources*
  - *We must use dollars wisely*
  - *No room for waste*
- *Yet, distribution of medical equipment and facilities is often not adequate to need*
  - *e.g., one community has 8 MRI machines, another of same size has none*

RECOMMENDATION:

- *Review having a creditable "Certificate of Need" program to help match need with resource availability.*

CLOSING COMMENTS

- *Task of health care reform daunting and complex*
- *Archimedes Movement estimates it will take 10-15 years to bring meaningful reform*
- *Your work is important, we support and encourage your leadership*
- *GCSS wishes you best of success*
  - *Let us know how we can help you*

Bibliography

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3. *Munnell, Alicia H., et al. "Health Care Costs Drive Up The National Retirement Risk Index", Center for Retirement Research at Boston College. Number 8-3, February 2008.*
4. *Wyden, Ron. "The Healthy Americans Act". Press Release February 18, 2008.*

Reflections and Recommendations on Health Care Reform

Governor's Commission on Senior Services

Presented to OHFB Federal Laws Committee 2/29/08 by:

- *Charles Frazier*
- *Robert Lawrence*
- *Peggie Beck*

ORIGINAL MEDICARE Physician reimbursement formula:

Medicare Claims Processing Manual (www.cms.hhs.gov/manuals/IOM)
Chapter 12 - Physicians/Nonphysician Practitioners

20 - Medicare Physicians Fee Schedule (MPFS)

Most physician services are paid according to the Medicare Physician Fee Schedule (MFPS).

A. Formula
The fully implemented resource-based MPFS amount for a given service can be computed by using the formula below:

MPFS Amount = [(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF

Where:
RVUw equals a relative value for physician work,
RVUpe equals a relative value for practice expense, and
RVUm refers to a relative value for malpractice.

In order to consider geographic differences in each payment locality, three geographic practice cost indices (GPCIs) are included in the core formula:
- A GPCI for physician work (GPCIw),
- A GPCI for practice expense (GPCIpe), and
- A GPCI for malpractice (GPCIm).

Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

30.4 - Localities for Pricing
The localities listed below are used to make Medicare payments for services paid under the physician fee schedule or linked to the physician fee schedule….:

Carrier	Number Locality	Number Locality Name
00903	01	DC + MD/VA Suburbs
00590	03	Fort Lauderdale, FL
00590	04	Miami, FL
00590	99	Rest of Florida
00805	01	Northern NJ
00805	99	Rest of New Jersey
00521	05	New Mexico
00803	01	Manhattan, NY
00803	02	NYC Suburbs/Long I., NY
00803	03	Poughkpsie/N NYC Suburbs,NY
14330	04	Queens, NY
00801	99	Rest of New York
00522	00	Oklahoma
00835	01	Portland, OR
00835	99	Rest of Oregon

(Thank goodness, there is an online tool for calculating physician fees.)

Medicare Advantage Monthly Capitation Rates for 2008

(www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD)

			*** Aged ***		*** Disabled ***	
Code	State	County name	Part A	Part B	Part A	Part B
38000	OREGON	BAKER.....	364.22	334.73	376.78	375.58
38010	OREGON	BENTON.....	364.22	334.73	376.78	375.58
38020	OREGON	CLACKAMAS.....	402.56	369.96	416.44	415.11
38030	OREGON	CLATSOP.....	372.39	342.24	376.78	375.58
38040	OREGON	COLUMBIA.....	402.56	369.96	416.44	415.11
38050	OREGON	COOS.....	364.22	334.73	376.78	375.58
38060	OREGON	CROOK.....	364.22	334.73	376.78	375.58
38070	OREGON	CURRY.....	364.24	334.75	376.78	375.58
38080	OREGON	DESCHUTES.....	364.22	334.73	376.78	375.58
38090	OREGON	DOUGLAS.....	364.22	334.73	376.78	375.58
38100	OREGON	GILLIAM.....	364.22	334.73	376.78	375.58
38110	OREGON	GRANT.....	364.22	334.73	376.78	375.58
38120	OREGON	HARNEY.....	364.22	334.73	376.78	375.58
38130	OREGON	HOOD RIVER.....	364.22	334.73	376.78	375.58
38140	OREGON	JACKSON.....	395.13	363.13	376.78	375.58
38150	OREGON	JEFFERSON.....	364.22	334.73	376.78	375.58
38160	OREGON	JOSEPHINE.....	364.22	334.73	376.78	375.58
38170	OREGON	KLAMATH.....	364.22	334.73	376.78	375.58
38180	OREGON	LAKE.....	364.22	334.73	376.78	375.58
38190	OREGON	LANE.....	415.8	382.13	416.44	415.11
38200	OREGON	LINCOLN.....	364.22	334.73	376.78	375.58
38210	OREGON	LINN.....	392.29	360.53	376.78	375.58
38220	OREGON	MALHEUR.....	364.22	334.73	376.78	375.58
38230	OREGON	MARION.....	402.56	369.96	416.44	415.11
38240	OREGON	MORROW.....	372.12	341.99	376.78	375.58
38250	OREGON	MULTNOMAH.....	402.56	369.96	416.44	415.11
38260	OREGON	POLK.....	402.56	369.96	416.44	415.11
38270	OREGON	SHERMAN.....	364.22	334.73	376.78	375.58
38280	OREGON	TILLAMOOK.....	364.22	334.73	376.78	375.58
38290	OREGON	UMATILLA.....	364.22	334.73	376.78	375.58
38300	OREGON	UNION.....	364.22	334.73	376.78	375.58
38310	OREGON	WALLOWA.....	364.22	334.73	376.78	375.58
38320	OREGON	WASCO.....	364.22	334.73	376.78	375.58
38330	OREGON	WASHINGTON.....	402.56	369.96	416.44	415.11
38340	OREGON	WHEELER.....	364.22	334.73	376.78	375.58
38350	OREGON	YAMHILL	420.78	386.71	416.44	415.11
33420	NEW YORK	NEW YORK.....	565.31	519.53	511.13	509.49
33500	NEW YORK	NIAGARA	402.56	369.96	416.44	415.11
5400	CALIFORNIA	ORANGE.....	473.43	435.09	495.36	493.78
3060	ARIZONA	MARICOPA.....	402.56	369.96	416.44	415.11
10490	FLORIDA	PALM BEACH.....	531.16	488.14	520.35	518.68

Although there are noticeable differences, any reader would need to study the source material carefully to interpret the differences correctly. There are also categories for ESRD and Risk capitation rates.

MEDICARE ALPHABET

PART A Hospital / facility coverage

PART B Medical / outpatient coverage

(Both of these pay 80%, so most people need something to fill the "gap." Thus the name "Medigap.")

PART A + PART B + MEDIGAP is called Original Medicare

PART C Was "Medicare + Choice", now called Medicare Advantage. "Gap" coverage is through a managed care plan (HMO-PPO-PFFS)

PART D Effective 1-1-2006 - Prescription drug coverage, available to all people with Medicare Part A & B *or* Medicare Part A *or* Medicare Part B

VOLUNTARY - if you don't have a drug plan with coverage "as good as" Part D (also referred to as creditable coverage), and decide NOT to sign up for a Part D plan, there is a 1% penalty per month of delay and you may have to wait until annual open enrollment.

VERY IMPORTANT – Even people who have drug coverage may want to compare plans to make sure they have the best coverage for their needs. Most Medicare Advantage plans offer Prescription Drug Plans (MA-PD). Check with your plan to learn what you need to do to access drug coverage and continue in the Medicare Advantage Plan.

Note – There is extra financial assistance to help people with limited income/resources to pay for Part D.

Social Security 1-800-772-1213
Medicare 1-800-633-4227

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
877-416-4161 (TTY/TDD)
www.careoregon.org

Federal Laws Committee
February 14, 2008
Testimony of Pam Mariea-Nason

Hello, I'm Pam Mariea-Nason from CareOregon. We are the state's largest Medicaid managed care plan with just under 100,000 members. We also have a Medicare Special Needs Plan (SNP) that covers about 6,000 of our dually eligible members.

It is a challenge to articulate all of the ways that the federal government impacts our State Medicaid program. The report that DMAP created and supplied to you in January is a terrific discussion of many of the challenges we face. My fellow panelist will elaborate further on many of those points.

Our state, like all others, is challenged with managing the polarity of wanting to maximize the amount of our federal tax dollars that come back into Oregon and at the same time, maintain as much autonomy and ability to develop and manage our own programs without federal interference. Its okay for the federal government to have "oversight" it is a much different prospect to give up control in exchange for dollars. Quite frankly, different federal administrations bring different "personalities" to the relationship between innovative states like Oregon, and large federal entities like CMS. Our current federal administration has been eroding opportunities for innovation at the state level in many cases through limiting funds and eligibility through new mandates like the Deficit Reduction Act, CMS enacting rules that seem shortsighted and confused as well as dragging their feet on responses to the states requests for waivers or waiver amendments.

As you know, the Medicaid program has to focus a lot of energy on how money flows into the program, and how money flows back out. In Oregon, we have a very unique model of community based delivery systems and health plans that receive a global capitation rate to manage the physical health of the population they are responsible for. The same is true for mental health and dental health. We are the only state that used a prioritized list to help us allocate resources. In many places outside of Oregon, the OHP is still viewed as a great model.

In 1987 when the original visionaries got together, they envisioned a program that would provide access to all Oregonians. They said “all citizens should have universal access to a basic level of care”. The original idea as I understand it was to have government, insurers, individuals and businesses contribute in way that maximized our federal matching dollars. As the story unfolds, we are unable to get an ERISA waiver for the employer piece and that funding stream evaporates. There is obviously more to that history and understanding that can help inform the work of HFB. Here we are 20+ years later, and we don’t even have any state general funds allocated to a large portion of the “expansion” population that was intended to be covered. Not covering the “standard” population as we now call it results in “cost shifting” to providers and payors and all of us that can be directly traced to our uninsured citizens.

So what’s a state to do…Funding. Funding. Funding. We need state general fund dollars.

But let’s not just keep putting money into a system without thinking about whether the system is designed to give us what we want for our population.

One way to help manage the costs of healthcare, and improve the “bang for the buck” that we are putting into the system is to think about how we deliver and pay for care. Our current healthcare system is too expensive for the outcomes it is delivering to our population. If we had excellent comparative outcomes we might not think we’re spending too much. But we don’t.

We are constrained by modeling our payment to providers based in large part on what CMS does with their payment codes. This is not only true in Medicaid, but for much of the commercial insurance market as well. As an example, physician services that have a large technical or procedural component “weigh more” and we pay significantly more for those services. The services that are called “cognitive services”, much of disease prevention or chronic care management work are valued less, and therefore are paid for at a lesser amount.

We use that model for several reasons. It has been that way for years and years. It is easier on providers to have one billing system. When the health plans submit our payment history to DMAP, our services are valued on this system, and our future capitation payments are a result of that valuation. I believe DMAP uses this system to report to the Federal Government which drives the matching dollars back into the state. If the Medicaid health plans pay for services that are not valued or paid for by CMS we may not receive the matching dollars.

Let me give you an example. What we do know is that coordination of care at a primary care level can result in better health for people and save significant money in the whole system. Having a nurse, as an example, provide these services is not something that is valued or paid for at this time. Any coordination that happens by that nurse is considered “part of the overhead expense”. Clinics bear the cost of that overhead expense, without reimbursement to cover that cost. If we could pay for that service, we

believe we would save dollars in the system and improve outcomes. The good news is that CMS actually adopted some new codes in 2008 that may allow for this type of service.

We want to have flexibility in how we pay clinicians so that we can help transform the delivery system to provide the care our members need for less cost.

Hopefully, the HFB and committees will look for as many opportunities to provide that flexibility for the Medicaid plans as well as any company paying for services in Oregon. Medicaid has the unique need to make sure we can acquire matching funds, and we need to work with CMS to see what flexibility we can develop.

HIPAA and communication

I want to touch briefly on an issue that prevents the type of care coordination that I outlined above. You may be familiar with the federal regulations around the sharing of clinical information and privacy and security of that information.

Different funding streams at the state level for the same individuals result in confusion and hesitation around what information can be shared across plans. This results in uncoordinated care, duplication of administrative services, and member confusion.

"Payment, treatment or operations" which are the situations in which you can legally exchange clinical information doesn't seem extended to our working relationship with our partner plans.

Communication of clinical information will be essential to the improvement of healthcare delivery, and hopefully the experience of the individual. It's hard to coordinate care if you can't communicate about it. This leads to excess costs and poorer treatment outcomes.

We need clear analysis of the impact of HIPAA and state regulations on communication between providers and plans, and guidance from the HFB.

In summary. Reform needs to be built on a foundation of Medicaid so that we can maximize our federal matching dollars. Otherwise, we leave between 60-70 cents of every dollar on the table.

As the largest single payor, the state has the opportunity to create change in how care is delivered, paid for and in how and what we can communicate. We can start at the primary care level because it will improve patient care and reduce costs.

Clearly we have a lot of work to do with CMS to make that happen.

Lipa

Testimony for Federal Laws Committee
Oregon Health Fund Board
February 14, 2008

Good morning. My name is Rhonda Busek. I am the Chief Operations Officer for Lipa or Lane Individual Practice Association. Thank you for this opportunity to speak with you. Lipa is a Fully Capitated Health Plan (FCHP) that contracts with the State of Oregon to manage the Oregon Health Plan in Lane County. Currently our membership is approximately 26,500 members in Lane County.

There are three issues I would like to discuss with you this morning in regards to the impact of Federal Laws on Lipa as a Medicaid Managed Care Plan.

1. In follow-up to Pam's testimony regarding increasing payment to providers, Lipa fully supports increased payments to our providers. In addition to increased payments, Lipa supports Graduate Medical Education programs. CMS has proposed to no longer allow Medicaid funding to be used for Graduate Medical Education programs. This action has been delayed by Congress until 5-25-08. Additional action will be needed to withdraw this proposal. Lipa believes it is very important to continue support of these programs to help train future doctors and to pay for Medicaid services provided by residents. Teaching hospitals are critical to maintaining Oregon's supply of new physicians.

2. The system is very complex. Timeliness of approvals from CMS often does not leave much time for implementation by the plans. This can leave the plans in limbo waiting; preparation time is crucial.

    A. From a Plan perspective -- Currently, there is an effort by the federal government to decrease funding while there is an effort by DMAP to increase the number of members served. Different approaches lead to different interpretations of rules by both entities. This can lead to conflicting interpretations of rules between DMAP and CMS. Currently, most of the FCHPs have corresponding Medicare Plans. The plans receive interpretations from both CMS and DMAP that can be confusing though basically the same rules. An excellent example of this is the requirements for Quality Improvement. Can we align our DMAP projects with the requirements of Medicare? Is there anyway to streamline reporting so that projects can cross over from the FCHP's Oregon Health Plan to the FCHPs corresponding Medicare Plan? A proposal was submitted to DMAP addressing the opportunity to streamline. DMAP did take the proposal to CMS and the proposal was not accepted. DMAP has worked with the plans to streamline processes by removing the Current Milestone Reports from the Contract. We are hopeful that we can continue to streamline processes and reporting when possible.
    B. From a Member perspective – The application process is very tedious and hard to understand. Currently DMAP is working to decrease the number of pages in the application process.
    C. From a Provider Perspective – The processes are very cumbersome leading to increasing administrative costs.

3. Deficit Reduction Act (DRA): The DRA created requirements that all individuals applying for or recertifying for certain Medicaid programs will have to prove US citizenship by presenting specified documentation. When this requirement was implemented, this became a hardship for some of the most vulnerable including the homeless, physically disabled, patients with mental illness, infants and children in foster care. This was often due to a member's lack of funds to obtain embossed copies of their birth certificates. During the first six months of implementation, this requirement affected nearly 500,000 Oregonians. Approximately 1,000 citizens lost or were denied benefits because they were unable to meet the new federal requirements. Many of these

Lipa

were infants and children. Issues identified during the initial implementation: Lack of time, lack of money, lack of transportation, complicated and confusing process, and missing affidavits for identify documentation. This requirement only applies to US citizens. Non-citizens continue to show proof of legal immigration status as they have in the past. Undocumented aliens continue to be eligible for the Citizen Alien Waived Emergency Medical (CAWEM). This new requirement has meant some applicants are being denied appropriate medical care because members are unable to meet new federal requirements for proof of identify and documentation. This could lead to a delay in receiving medical care. This can also lead to unnecessary out of pocket expenses.

Thank you for your time.

Rhonda Busek
Chief Operations Officer
Lipa

Capitol Dental Care, Inc.

3000 Market Street Plaza NE, Suite 228 • Salem, OR 97301 • (503) 585-5205 • Fax: (503)581-0043

1) Medicaid federal policy, with the last 2 surgeon general's stressing the importance of oral health in overall Medicaid should include dental as mandatory for all ages, versus optional for adults as it is currently.

Surgeon General Dr. C. Everett Koop, "You're not healthy without good oral health." His recommendations oral health must become a much higher priority at the local, state, and national levels, so that oral health disparities can be resolved. The federal government must be a role model and set the example that oral health is an integral and important component of all health programs.

Surgeon General David Satcher indicated a lack of awareness of the importance of oral health among the public. He found significant disparity between racial and socioeconomic groups in regards to oral health and ensuing overall health issues. Based upon the findings, he called for action to promote access to oral health care for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

This statement is supported by a broad based dental stakeholders group of which CDC is a part of.

2) Medicaid prohibits use of procedure code D9630 for take home dispensing. American Dental Association's description of code includes take home dispensing. With paradigm shift of dental disease as an infectious disease, many dental products are currently available and being developed to treat the disease as such. This exclusion under Medicaid will limit use of these types of products (as clients/enrollees will not afford out of pocket). These types of products if utilized could avoid or reduce the need for much more costly restorative dental care.

Dental disease is an infectious disease of which certain products being developed are to reduce or eliminate the infectious bacteria and promote re-mineralization.

3) Medicaid case law prohibits the billing or submission of encounter data for a service if free to any others at the same time it is provided. This is not just applicable to dental. Although resources are too important to duplicate services irregardless of the setting, this limitation will make it difficult for creative options to be pursued in bringing care to where clients/enrollees are i.e. schools, WIC, etc.

applicable to dental. Although resources are too important to duplicate services irregardless of the setting, this limitation will make it difficult for creative options to be pursued in bringing care to where clients/enrollees are i.e. schools, WIC, etc.

Surgeon General Koop further recommends, promotion and use of individual and population-based prevention services and programs must become a much higher priority at the local, state, and national levels, especially for children and high-risk populations.

4) Medicaid does not allow billing a client/enrollee a no show fee. Dentistry is procedural based and often a large block of time has been scheduled for an appointment. When a client/enrollee does not show up for a dental appointment the provider loses valuable time. Our state allowed no show fee and was told by the federal government to stop. One of the number one reasons dentists give for not wanting to participate in OHP is high % of no shows. Since removing the no show fee the incidence has gone up, a no show fee is a deterrent. Medicare is re-evaluating its position on no show fees, Medicaid should consider the same

Sincerely,

Deborah Loy

Deborah Loy
CDC OHP Services Director

Mid-Valley Behavioral Care Network
1660 Oak Street SE, Suite 230 ▪ Salem, Oregon ▪ 97301
PHONE: (503) 361-2647 ▪ FAX: (503) 585-4989 ▪ www.mvbcn.org

Memorandum

To: Federal Laws Committee, Oregon Health Fund Board

From: Jim Russell

Date: February 14, 2008

Subject: Mental Health Organization Perspective

My name is Jim Russell; I am the leader of the Mid-Valley Behavioral Care Network, one of the nine Mental Health Organizations that contract with Department of Human Services to provide Oregon Health Plan mental health services throughout Oregon. I have included an Oregon map to show you the names and service areas of the MHOs. My interests in health care reform in Oregon include my service as vice-chair of the Enrollment and Eligibility Committee of the OHFB, and as co-chair of the Medicaid Advisory Committee.

From your speakers for this meeting, and your past meetings, I believe you will hear all the relevant federal issues related to Medicaid mental health care in Oregon. I won't take your time to repeat material you have already heard. In addition, I will rely on the January 2008 DMAP report "*The impact of federal policy on Oregon's health care reform efforts*" and point out the application of certain sections to mental health services. In my opinion we receive extraordinary staff work from the Office of Health Policy and Research, and from the Division of Medical Assistance Programs, in support of this health care reform planning.

The federal challenges to mental health care in Oregon are primarily regulatory changes from the Centers for Medicare and Medicaid Services (CMS). In the DMAP document the processes of CMS regulation are summarized on pages 26 and 27, and on page 36 the document notes how in recent years CMS administrative actions "have shifted billions of dollars in federal costs to states".

<u>CMS changes in the definition of case management</u>

The DMAP report, pages 29 through 34, describes the opportunities and barriers presented by the Deficit Reduction Act (DRA) of 2005. Among the barriers is a CMS re-definition of case management (page 30) which will restrict current practice dramatically. As a mental health service, case management is critical to assist people with mental illnesses to access necessary services and supports for successful community life. I will provide to Committee staff a detailed comparison of DRA language and the CMS regulations proposed to implement DRA. In a cover letter for this analysis the American Public Human Services Association asserts that "this regulation goes far beyond the original language and intent of the DRA" and will cause "major disruptions and significant additional costs … in nearly every state". This regulation takes effect March 2008 and was done as an interim final rule without prior public comment.

New CMS requirements for government provider cost reporting and cost limitations

The DMAP document, Attachment E, the first row, page 1, references new government provider cost reporting. Public mental health care in Oregon is provided by both public and private entities. The public (county-run) community mental health programs will fall under these requirements. The regulation allows no margin for working capital, risk reserves, carry-forward funds, etc. Any "unspent" funds must be refunded to the federal government. The consequences of the requirements will at least include increased administrative costs and decreased services; in the extreme it will be very difficult for governmental entities to provide (mental) health services. Congress has succeeded in passing a moratorium, delaying implementation until May 25, 2008 (see Attachment F, page 1).

CMS changes in the definition of rehabilitation services

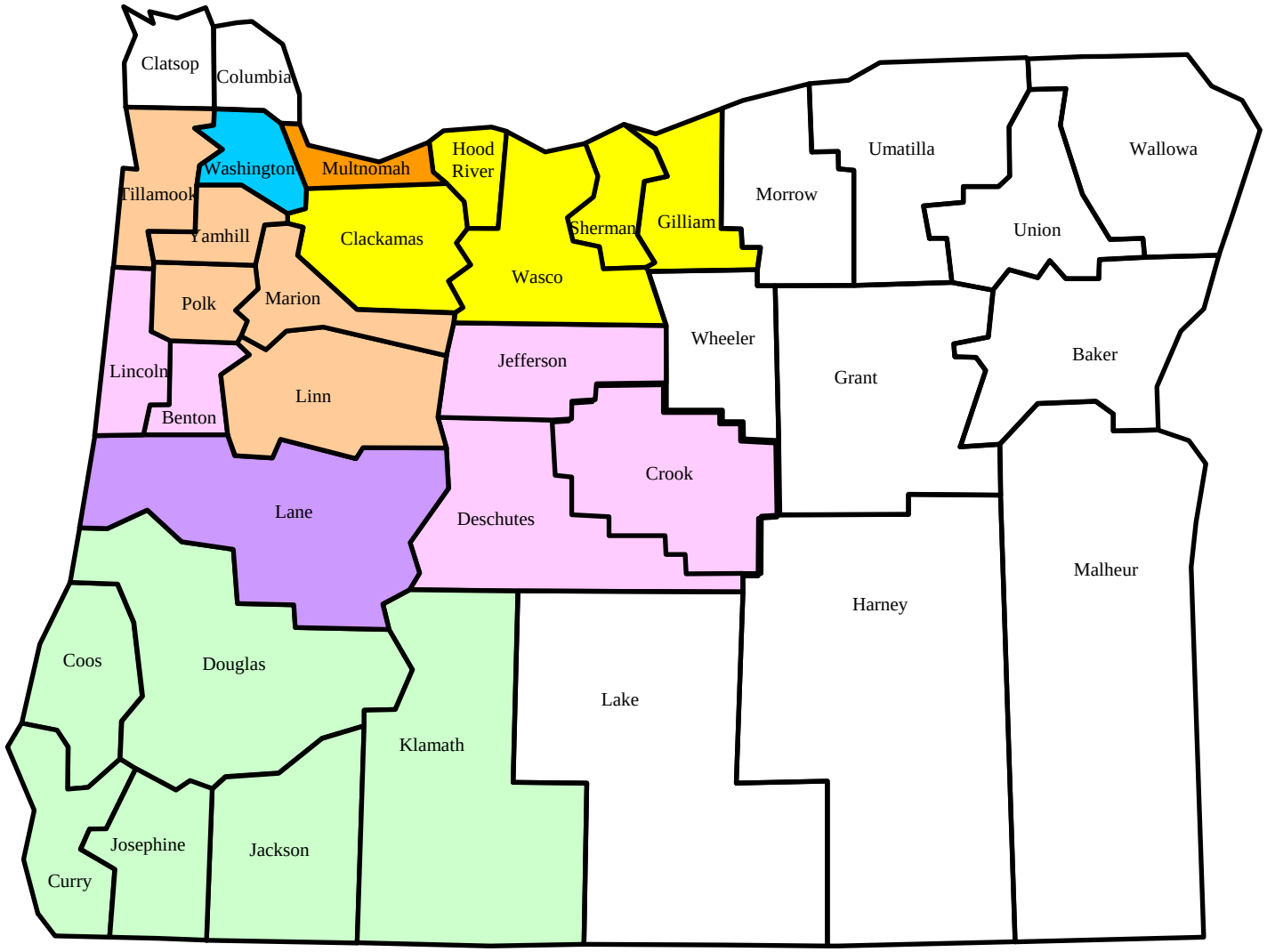
This topic is listed in the DMAP document, Attachment E, last row, page 4. The Secretary of the Department of Health and Human Services proposed similar restriction in definition to be included in the DRA but Congress rejected it due to serious concerns regarding its impact on access to community living for individuals and the financial strains it would place on state and local governments. For someone with a mental health disability, rehabilitation must include employment, housing and community tenure skills; services may be required to maintain a functioning level without advancing to a higher functioning level. The regulations would greatly narrow current services. In October 2007 the National Governors' Association urged CMS to rescind the proposed rule, predicting that the rule would "limit Medicaid coverage of these services and shift costs to already overburdened state mental health systems". The same month the National Association of State Mental Health Program Directors concluded a letter to CMS: "NASMHPD recommends strongly that the regulation be withdrawn and that Congress and CMS involve the mental health community and other stakeholders in a thorough evaluation of the rehabilitation option and its effectiveness in providing recovery-oriented services to those with mental illness". Congressional action has delayed implementation of this regulation until June 30, 2008 (see Attachment F, page 2).

CMS capitation rate-setting checklist

{If this hasn't covered by others I will make a few comments on this topic}

I want to close by directing your attention to a recent letter addressed to the U.S. Congressional Leadership from the American Public Human Services Association and the National Association of State Medicaid Directors. About the CMS actions that are listed in the DMAP Attachment E, these national associations assert: "The end result will be reduced access, lower quality of care and fewer people with health coverage." This is the opposite direction than that proposed in SB 329, so I urge that the Federal Laws Committee include these considerations in their advocacy.

Mental Health Organizations (MHOs) Service Areas



ABHA
Benton, Crook, Deschutes, Jefferson, Lincoln

Clackamas
Clackamas, Gilliam, Hood River, Sherman, Wasco

FamilyCare
Clackamas, Multnomah, Washington

GOBHI
Baker, Clatsop, Columbia, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Wallowa, Wheeler

JBH
Coos, Curry, Douglas, Jackson, Josephine, Klamath

LaneCare
Lane

MVBCN
Linn, Marion, Polk, Tillamook, Yamhill

Washington County
Washington

Verity
Multnomah

National Alliance on Mental Illness

Addressing Barriers to Effective and Integrated Mental Health Care

Oregon Health Fund Forum

Federal Laws Committee

Portland, OR

February 14, 2008

The Oregon Health Fund Board

First Design Principle:

- **Optimize Health**
  - *Wellness, prevention, early intervention and chronic disease management are strategic priorities*

Key Design Assumptions:

- *Reforms can improve health outcomes and contain historic patterns of annual cost increases*
- *Efficiency, quality, safety & consumer satisfaction are key to value*

National Alliance on Mental Illness

OHFB Federal Laws Committee

- **Identify federal barriers to more efficient use of federal dollars in covering lives and optimizing health**
  - *Focus of this presentation will be on barriers to effective and integrated mental health care*

National Alliance on Mental Illness

Addressing Barriers to Effective and Integrated Mental Health Care

Facts

- **One in four adults**—over 57 million Americans—experience a mental health disorder
- **One in seventeen** lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder
- **One in ten** children have a serious mental or emotional disorder

Implications for promoting health

- High need for **coverage** for mental health care
- High need for routine **access** to mental health care
- Need for **intensive mental health services** and supports for high-risk population

Fewer than one-third of adults and half of children with a mental disorder receive any mental health services in a given year.

Fact

- Half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24

Implications

- Youth and young adults ideal target for **screening and early intervention**

Fact

- Despite effective treatments, there are long delays—sometimes decades—before people seek and receive treatment

Implications

- Need for **outreach and education**
- Need to **reduce stigma**
- Need for **primary care integration**

Facts

- A.C.E. Study—Extraordinary correlation between number of **adverse childhood experiences** and **mental illness and other poor health outcomes**

Categories of "adverse childhood experiences"

- Physical , sexual, and emotional abuse and neglect

– Growing up in household where:

- Someone in household in prison
- Mother treated violently
- Drug user or alcoholic in household
- Someone in household with mental illness
- Loss of at least one biological parent

- Examined the health and social effects over the lifespan

The Adverse Childhood Experiences Study

- ACEs are strong predictors of health risks and disease

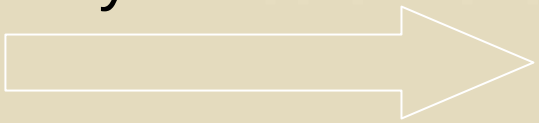
ACE Score	*Prevalence*
0	**36%**
1	**26%**
2	**16%**
3	**10%**
4 or more	**12.5%**

- Almost 3/4 have at least one ACE
- If one ACE is present, there is an 80% likelihood of another

Effects of Adverse Childhood Experiences

Affect

- Difficulty controlling anger
- Depression
- Panic reactions
- Anxiety



Risk Behavior

- Smoking
- Overeating
- Alcoholism
- Suicide
- Promiscuity
- Self-injury
- Eating disorders

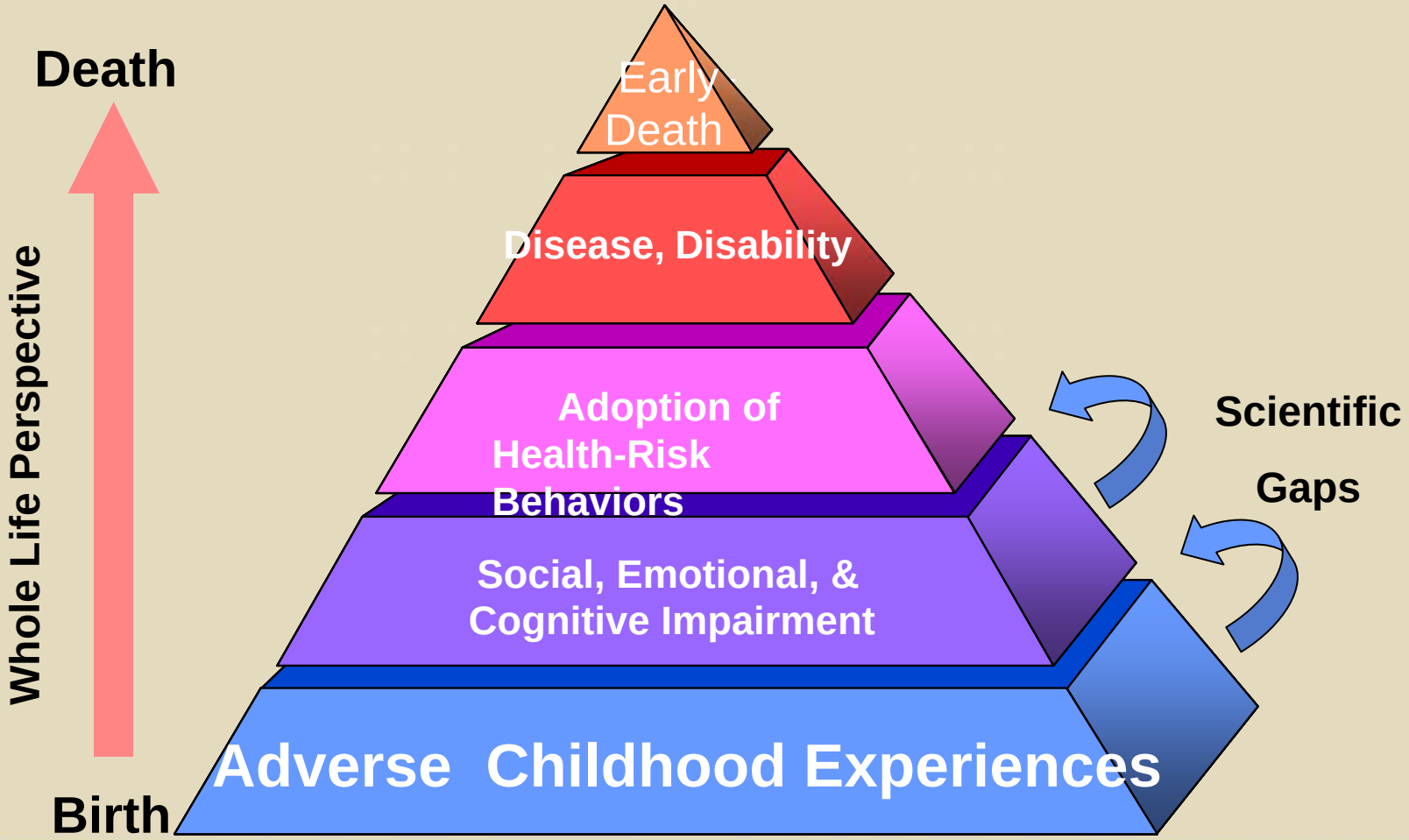
Evidence from the ACEs study suggests:

- Adverse Childhood Experiences are the most basic cause of health risk behaviors

- Health risk behaviors are the most basic cause of morbidity, disability, mortality and healthcare costs

National Alliance on Mental Illness

The ACE Pyramid: A Conceptual Framework



Implications

- Reduce incidence of adverse childhood experiences to yield high return on health
  - Screen for childhood risk factors
  - Provide trauma-informed and trauma-specific mental health services
  - Provide effective interventions for parents, heads of households

Fact

- Persons with serious mental illness die an average of 25 years younger than their peers, largely of treatable health conditions

Implications

- Persons with serious mental illness need **better and more integrated health and mental health care**

Fact

- Adults with common medical disorders have high rates of depression and anxiety
- Depression impairs self-care and adherence to treatments for chronic medical illnesses
- Depression increases the risk of dying from heart disease by as much as three-fold
- Individuals with diabetes and co-morbid depression have healthcare costs that are 4.5 times higher than those without

Implications

- **Treatment for co-occurring health and mental health conditions would improve outcomes**

Align incentives to promote health

- Examine role of private health care
  - Private health care lags public sector in treating serious mental illness effectively
  - Benefit from cost shift to public sector
- Increase self-care through non-punitive policies
- Promote continuity of care in eligibility and re-enrollment policies

Align incentives to promote health

- Provide financial incentives for identification, treatment, and coordination of mental health, substance abuse, and other medical care
  - Mental health services as a basic need
  - Outreach and education
  - Primary care integration
  - Screening and early intervention
  - Trauma-informed and –specific services
  - Treatment of co-occurring disorders
  - Chronic care models for serious mental illness

Federal Barriers

- SCHIP (State Children's Health Insurance Program)
  - Current law allows SCHIP benchmark plans (in states that use a private group health plan option) to cover mental illness at only 75% of the actuarial value of other medical benefits
  - No requirement that benchmark plans provide equitable duration treatment limits and financial limitations, including cost-sharing, deductibles and out-of-pocket limits for mental health benefits
  - Benefits do not need to include evidence-based interventions for serious mental conditions covered by Medicaid plans, such as intensive case management, Multi-Systemic Therapy, Functional Family Therapy, etc.

Ideas to Address Barriers

- SCHIP (State Children's Health Insurance Program)
  - Require full parity of mental health coverage in all SCHIP plans
  - Require all SCHIP plans to cover evidence-based practices for serious mental health disorders
  - Reduce cost-sharing for chronic conditions, including mental health disorders (value-based)

Federal Barriers

- Medicare
  - 50% co-pay for mental health services
  - Since co-pays are often uncollectable, providers incur losses to provide services
  - Unequal inpatient day limit for MH
  - Lack of coverage for case management and evidence-based interventions
  - Benefits rely on "medical model" of office visits and medications
  - Only certain licensed professionals are billable

Ideas to Address Barriers

- Medicare
  - Establish full parity for mental health services to Medicare Part B
  - Cover range of effective mental health services covered under Medicaid options
  - Expand array of billable providers, paraprofessionals, etc. to align with Medicaid
  - Reduce cost-sharing for chronic conditions, including mental illnesses (value-based)

Federal Barriers

- Medicare Part D
  - No coverage of benzodiazepines (used with manic episodes, etc.)
  - Low Income Subsidy assets and income tests are too low
  - Late enrollment penalty for Low Income Subsidy
  - Cost sharing requirements
  - Plans are allowed to change formularies mid-year, resulting in beneficiaries without adequate coverage

Ideas to Address Barriers

- **Medicare Part D**
  - Restore coverage of Benzodiazepines
  - Eliminate cost-sharing for certain non-institutionalized dual elgibiles
  - Higher income limits and asset tests to qualify for Low Income Subsidy
  - Waiver of the late enrollment penalty for the LIS
  - Limit cost sharing for LIS beneficiaries
  - Allow mid-year enrollment changes for beneficiaries adversely impacted by formulary changes
  - Insitute “intelligent assignment” for low-income beneficiaries into plans that more adequately cover their medicaitons
  - Provide 90-day enrollment periods for subsidy-eligible individuals

Federal Barriers

- Medicaid
  - **IMD exclusion** for facilities over 16 beds that primarily serve individuals with mental illness
    - Result in **no Medicaid match** for most state hospital patients
    - Presents barriers to developing financially viable facilities
    - Results in difficulty meeting Medicaid budget neutrality requirements for home and community-based waivers

Ideas to Address Barrier

- **Repeal or modify IMD exclusion** that prevents federal participation in needed facility-based care

Federal Barriers

- Medicaid
  - **Restrictions on billing more than one service** per day—resulting in lack of integration and consultation

Ideas to Address Barriers

- **Revise regulations** that prevent efficient consultation and treatment coordination and integration, including same-day services, telephonic and electronic consultation, etc.

Federal Barriers

- Medicaid
  - **Proposed rule revisions,** including Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices

Ideas to Address Barriers

- **Extend moratorium on Medicaid rule revisions into 2009**
- **Realign rules and billing** to facilitate evidence-based practices, maintenance of health, and long-term health outcomes

Federal Barriers

- Medicaid
  - Disability criteria (unable to work) for eligibility
  - Enrollment processes and requirements

Ideas to Address Barriers

- **Redesign disability criteria** to better encompass individuals with psychiatric disabilties
- **Revise enrollment processes and requirements** to streamline applications and remove barriers for those who are homeless, incarcerated, etc.

Federal Barriers

- Medicaid
  - Benefits tied to unemployment status
  - Termination or suspension of benefits while incarcerated

Ideas to Address Barriers

- **Maintain Medicaid eligibility** for beneficiaries who work and who have a serious mental illness
- **Revisit suspension/termination** of benefits for youth and adults with chronic health/mental health conditions

Federal Barriers

- Medicaid
  - Disease focus, diagnosis-dependent

Ideas to Address Barriers

- Medicaid
  - Realign rules, financing, and billing to incentivize
    - Outreach
    - Screening
    - Wellness
    - Access to care
    - Early intervention (both age and stage of illness)
    - Evidence-based practices
    - Maintenance of health
    - Long-term health outcomes, including stable housing and employment

National Alliance on Mental Illness

For more information, please contact
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Testimony Before the
Federal Laws Committee
Of the
Oregon Health Fund Board

February 14, 2008

For the record my name is Scott Gallant. I am the Associate Executive Director of the Oregon Medical Association (OMA). For those who do not know me, I previously was the Director of Government Affairs for the OMA for twenty-five years and have served and still serve on two American Medical Association advisory groups on state and federal health policy and legislation.

As a further disclaimer, I should mention that the OMA supported both adoption of Senate Bill 329 and former Governor John Kitzhaber's attempts at including Medicare issues in Oregon's effort to develop comprehensive health reform at the state level. Simply put, long term sustainable health care reform cannot succeed without federal reform.

The OMA has also gone on record supporting U.S. Senator Ron Wyden's Healthy Americans Act, S. 334. Generally speaking, Senator Wyden is proposing that the health care system be changed from a defined benefit employer-provided system to an individually-owned defined contribution insurance product that would essentially eliminate the Medicaid Program as we know it today. His legislation would utilize private insurance products and pay physicians and other health care providers commercial rates of reimbursement. I have suggested to Senator Wyden, knowing the rapidity by which the U.S. Senate acts that he might want to consider proposing that Oregon act as a test site to determine if his reform concept would provide high quality medical services for less cost. To date, as far as I know, he hasn't taken my suggestion seriously.

I appreciated Bruce Goldberg's presentation to this committee when it last met because he encouraged the Committee to consider ideas and issues beyond the current constraints imposed by Congress and the administration. By that I believe he meant that "maximizing federal funds" though fine, limits the state's and the Health Fund Board's options for envisioning a more rationale health care system - one concerned less with meeting the current irrational requirements of Medicaid but which really considers a better delivery system that provides patients the opportunity to maximize their health and reduces the use of acute care services.

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There are constraints within human nature as well, as reported in the New England Journal of Medicine "The Determinants of Health and Their Contribution to Premature Death" shows the following:

- Behavioral Patterns 40%
- Genetic Predisposition 30%
- Societal Circumstances 15%
- Health Care 10%
- Environmental Exposure 5%

This points out that there are many factors that affect the health of Oregonians and Americans - some of which not in the realm of medical care.

Common knowledge also suggests that an increase in the number of people being treated, an aging population and improved medical care is and will have an escalating impact on the economy. For example, in a report by the Agency for Healthcare Research and Quality
(AHRQ) stated that "[the] rise in the number of people being treated, rather than the rise in spending per case was the most important determinant of growth… for 16 of the 20 most expensive conditions."

It is also widely understood that 5% of people with the greatest health care expenses spend 49% of the overall health care dollar. The proportion of "spenders" who remained among the top 1% of spenders for two years doubled between 1996-1997 and 2002-2003. Lifetime expenses for Americans was $316,600 according to AHRQ and 37% of these resources were spent by those between the ages of 65-84 while 12% of lifetime expenses were spent by those 85 years of age or older. Managed care did not make a "statistical difference" in the concentration of health care expenses versus those enrolled in indemnity or PPO plans.

The structure of both the American and Oregon Health Care Systems drive just about everyone to avoid costs; this includes federal and state governments, employers, insurers, hospitals and many other sectors of the health care delivery system. Until the underlying structure of the delivery system is changed to discourage, if not prohibit, the type of incentives that are used today to defer, deny or to avoid appropriate health care services, these systems are bound to fail.

The OMA believes that universal coverage for all Oregonians and all Americans will go a long way in reducing the costs of the current health care system by realigning appropriate incentives for professional and personal conduct that promotes healthy behavior. Even if we accomplish that goal it should be kept in mind that health care costs will continue to rise, but probably at a more sustainable rate.

There are significant federal barriers to effective state health care reform that the Committee may want to consider in its deliberations.

- **Medicare geographic payment variations.** Oregon and many other regions of the country receive less federal resources than other parts of the country. Oregon specifically utilizes fewer Medicare and Medicaid resources by admitting patients into acute care facilities less often and for less time, thereby providing more outpatient services. Recently, Congresswoman Hooley and Congressman Blumenauer proposed a bonus payment for physicians in regions that are more cost effective. Unfortunately, the House provisions were not adopted in 2007.

- **Federal antitrust laws and Stark laws** inhibit the ability of physicians to provide effective care and encourage oligopolies. This clearly leads to increased cost pressures that neither federal nor state regulatory or cost measures can control.

- **Federal support for medical education should be increased.** Oregon and the rest of the country face a significant and severe physician shortage. Unfortunately, the Bush 2008 budget proposed the elimination of support for medical residences which will have a considerable impact on patient care in the near future.

- **Encourage the Oregon Delegation to develop and propose a long term strategy** and funding to develop the infrastructure to enable patients when necessary and appropriate to access necessary services outside of the inpatient acute care system. Ideally, incentives should be developed to assist medical practices and clinics to be available twenty-four hours for routine care.

- **Permanently establish a rational rural health policy** that recognizes that small communities do not have the financial base to support full time medical practices. Simplify the programs that exist and reduce the complexity of the current structure.

- **Revise the federal tax structure** to encourage individuals and small employers, if appropriate, to purchase health insurance.

- **Propose and adopt uniform standards** for payment, quality measures and reduce the overhead burden for the delivery of health care services.

- **Implement interoperability standards** before requiring quality measures, electronic prescribing and/or electronic medical records.

- At the federal level, at least require that all **Americans will be protected from catastrophic medical costs** that often lead to personal bankruptcy.

In summary, Oregon has been penalized for its efficient delivery system compared to other areas of the country. This unfortunately has a direct impact on physician services since Medicaid and increasingly commercial payers follow Medicare payment policies. For example, Providence recently decided to take the Medicare "budget neutrality adjuster" rule as a mechanism to reduce physician commercial payment and other Oregon insurers may follow their lead. Though Oregon has had success with some Medicare Advantage products, Congress should seriously consider reducing the subsidies it has currently authorized for Private Fee for Service Medicare Advantage products. Nationally, many of these plans simply put the average 20% subsidy on their bottom line.

I appreciate the opportunity to discuss these issues and will be happy to respond to any questions.

Oregon Medical Association
Policy Statement Regarding Health Care Reform
02/07/07

The Oregon Medical Association (OMA) supports state and/or federal health care reform efforts that provide universal health care coverage, access and services for all Oregonians regardless of economic status. Reform should create pluralistic delivery systems that promote appropriate and fair competition rather than policies that favor one delivery system of care over another. The OMA also recognizes and supports policy concepts that utilize state and federal resources to provide all Oregonians access to an adequate level (or basic benefit package) of medical services while enabling individuals to be responsible for their own medical needs.

The following principles will guide the OMA's efforts to enact health care reform legislation:

1. The overriding goal should be to improve the health of all Oregonians;
2. Every Oregonian should have access to a basic health care benefit package that is affordable and includes preventative, acute care services and chronic disease management;
3. Access to and financing for health care services should be a shared public/private cooperative effort that must have catastrophic coverage to protect individuals and families from financial ruin, and allow the purchase of additional services or insurance. The cost of universal coverage is to be shared equitably and proportionately by individuals, employers and government. Financing must be economically feasible, explicit, and sustainable;
4. Health care services should be prioritized by clear, objective medical criteria to maximize the health of the overall population;
5. The process for reform must be based on criteria that are publicly debated, reflect a consensus of social values, and considers the good of society;
6. Physicians, other health care providers and informed patients must be the primary decision-makers for each patient's individual health. Policies should be developed that create incentives that prioritize healthy lifestyles and recognize personal responsibility as well as improve medical quality and outcomes.
7. Physicians and other health care providers should be reimbursed at a rate that covers the true cost of providing medical services;
8. The disclosure of all charges and payments, should apply to all components of the health care system.
9. The medical tort liability system should provide fair compensation for individuals harmed by the delivery system, through an efficient process which promotes continuous quality improvement and patient safety. Physician liability insurance premiums should primarily cover payouts to injured patients. The system should have low overhead costs.
10. The health care system should include the level of resources necessary to sustain and develop a sufficient physician workforce that can provide access to health care services for all Oregonians.

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Oregon Statistics

22% of Oregon Uninsured Non-Citizen residents
78% Native naturalized

Uninsured Oregonians
56,000 = 400% FPL
81,000 = 300-399%
73,000 = 200-299%
365,000 = <200%

68% least 1 Full-time Worker
14% Part-time Worker
18% Non-workers

Uninsured by Race
- Asian – 9.7%
- White, non-Hispanic – 13.3%
- African-American – 14.1%
- American Indian – 27%
- Hispanic, any race – 32.5%

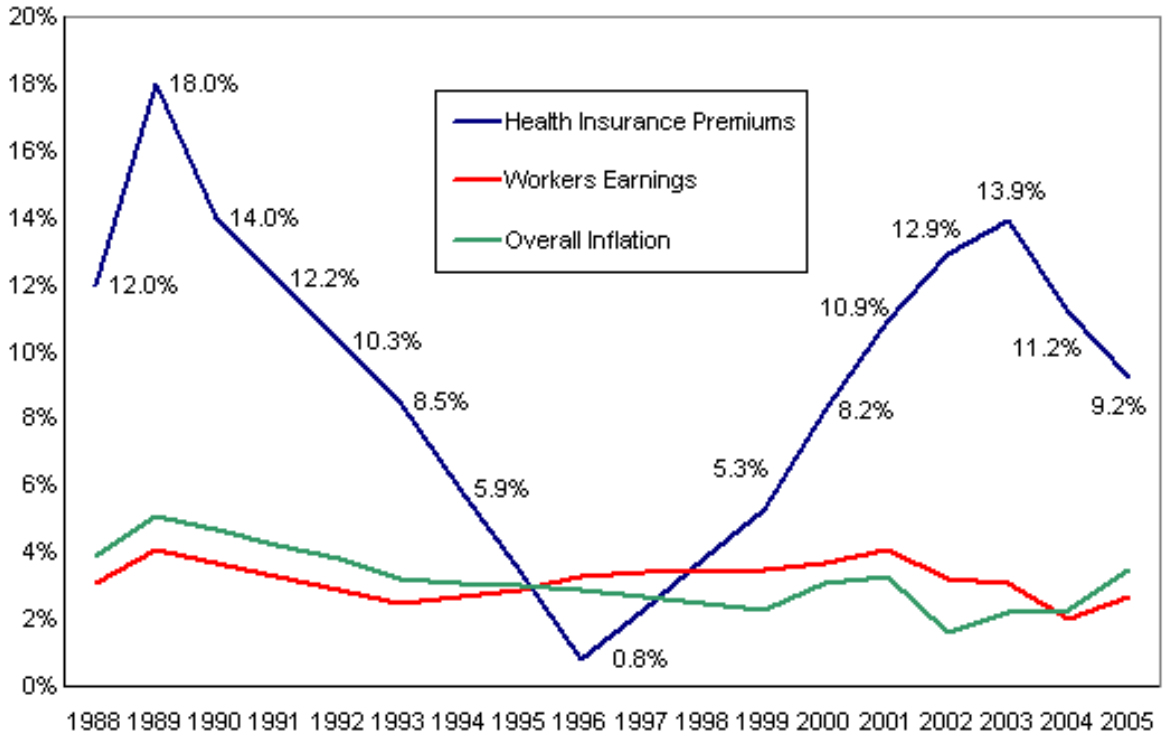
How long uninsured
12% 12 months
10% 10.2 months
18.5% 6-8 months
33% 3-5 months
26% <2 months

Source: Office of Health Policy & Research

Health Insurance Premiums

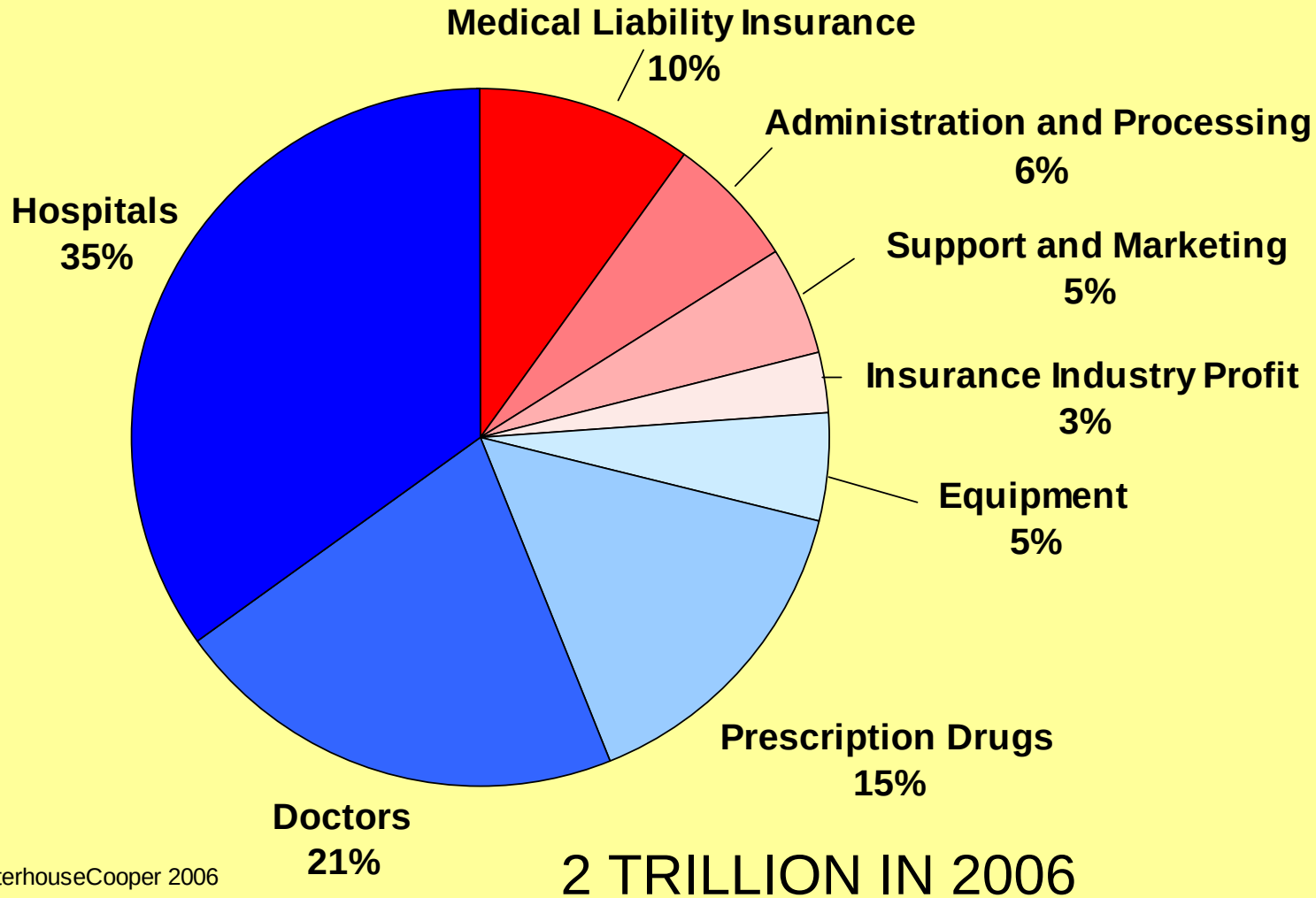
With a few exceptions, growth in health insurance premiums has been outpacing overall inflation and increases in workers earnings since the late 1980s.

Annual Growth Rates for Health Insurance Premiums, Workers Earnings, and Overall Inflation, 1988-2005



NEARLY ONE-QUARTER OF ALL HEALTH CARE DOLLARS ARE SPENT ON OVERHEAD

(Distribution of Americans' Health Insurance Payments, 2006)

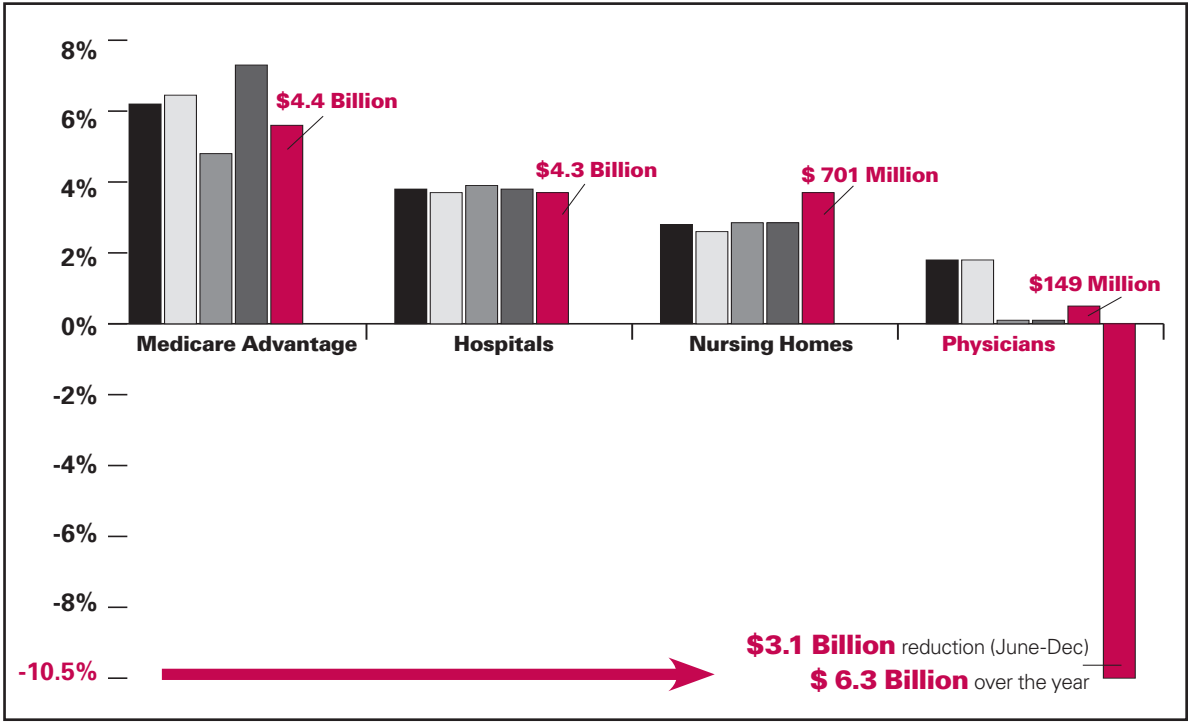


Source: PricewaterhouseCooper 2006

2 TRILLION IN 2006

Payments: Doctors vs. Other Medicare Providers

Doctors face a 10.5-percent cut in 2008, while other Medicare providers' payments continue to increase, keeping pace with their operations costs.



2004
2005
2006
2007
2008 (Jan-June)
2008 (June-Dec)

Physician Payments

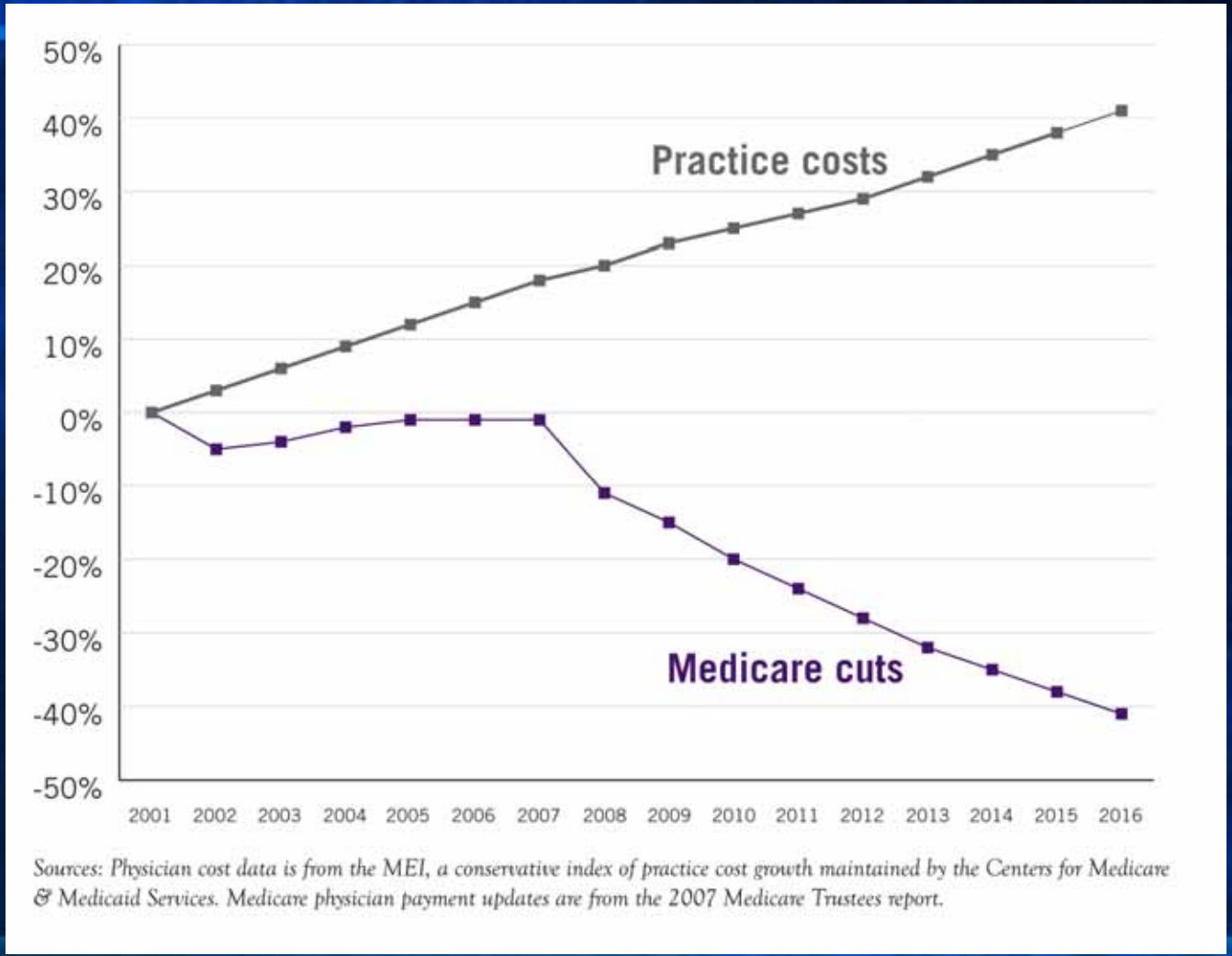
2004-05
1.5-percent increase

2006-07
0.0 percent

2008
(Jan-June): 0.05 percent increase

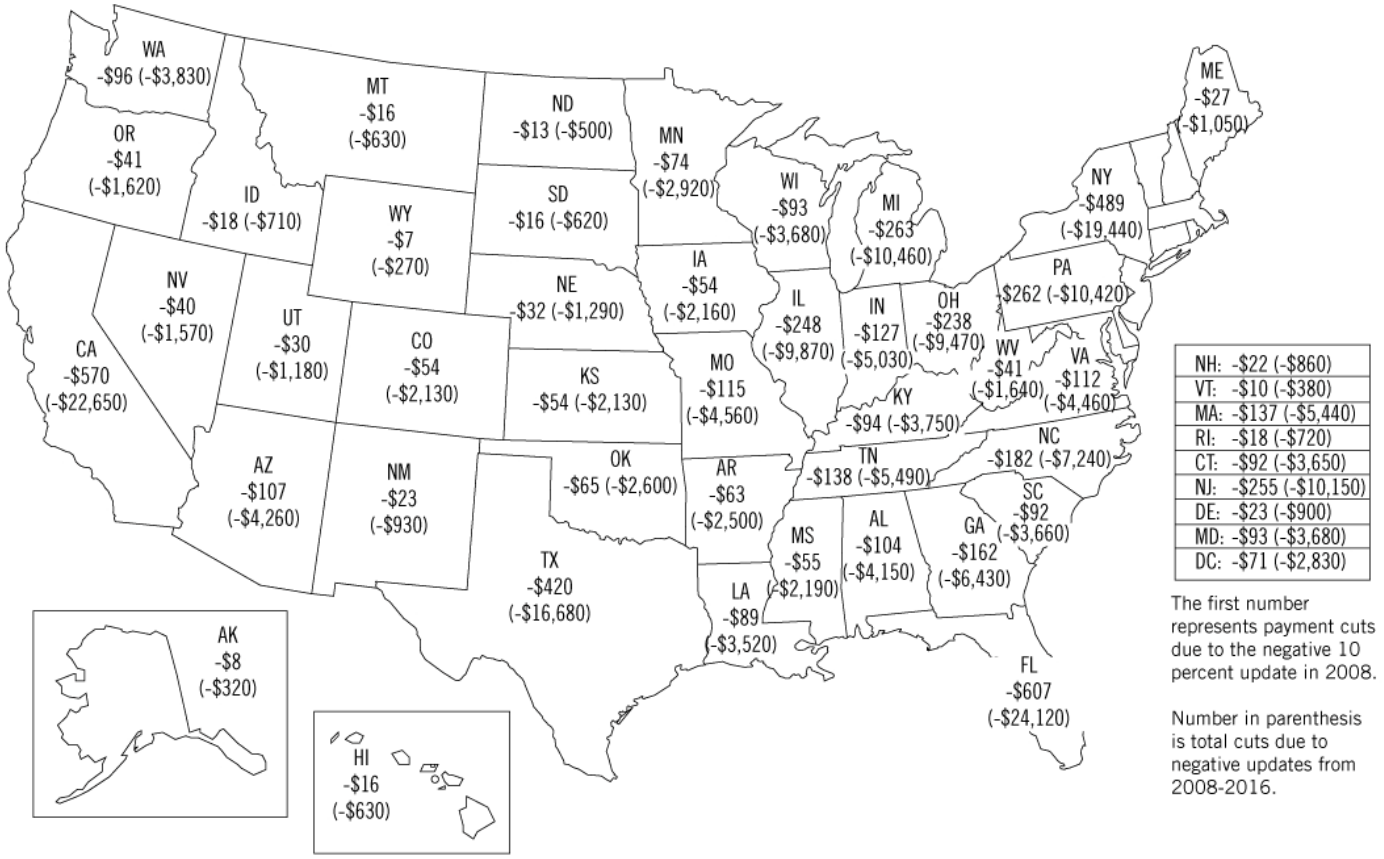
(June-Dec): 10.5-percent decrease

Replace the SGR formula system!



Sources: Physician cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2007 Medicare Trustees report.

Medicare payment cuts for physician services by state 2008-2016 (in millions)



Sources: The projected negative Medicare physician payment updates are from the 2007 Medicare Trustees Report. The source of the state-by-state analysis is the American Medical Association Division of Economic and Health Policy Research, May 2007.

PHYSICIAN PAYMENTS UNDER THE OREGON HEALTH PLAN:
TRENDS AND CONCERNS

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

- There are four types of organizations through which physicians can participate to provide services to OHP members. Reimbursement rates differ in each of the organizations.

- Benchmarks, which were calculated by Mercer, project expected costs of services for different provider groups. Data shows that physicians are being underpaid when their payments are compared to the Mercer Benchmarks.

- The methodology used by Mercer to develop the Benchmarks is questionable and results in understating what physician payments should be.

- Medicare payments (to which OHP payments are often tied) have decreased over the past ten years. It is projected that Medicare payments will continue to significantly decrease over the next ten years.

- OHP payment rates to physicians have been nearly flat since the OHP began in 1994.

- Total dollars paid to hospitals has continued to increase when compared to total dollars paid to physicians.

- Due to low payments, it is anticipated that many physicians will not be willing to participate as OHP providers in the future.

INTRODUCTION

The future success of Oregon's Medicaid program, the Oregon Health Plan (OHP), is dependent on maintaining a panel of providers willing to offer healthcare services at a reasonable rate of reimbursement. Most healthcare providers expect reimbursement levels from Medicaid programs to be paid at rates less than what Commercial carriers pay. Comparable discounts should be equally absorbed by the various healthcare groups[1] (also called "categories of service") that provide services to Medicaid members. In addition to being a matter of fairness, this is also the best means to assure continued participation by all those who are critical to the success and continuation of the OHP.

In 1999 and in 2001, Henery & Associates, Inc. was retained by the Oregon Medical Association to research the reimbursement received by physicians and hospitals participating as OHP providers. We found a significant disparity between these two provider groups. While both groups were receiving discounted payments, the physician discounts were much more severe than the discounts realized by the hospitals.

While this gap between the physicians and hospitals has increased, of even greater concern is the fact that physician reimbursement has remained virtually the same since the inception of the OHP in 1994. Regardless of the methodology used to measure reimbursement, the data shows that physician compensation has continued to fall short of payments received by other OHP healthcare provider participants.

This report focuses on both the underpayment to physicians compared to other OHP providers and presents data which illustrates that physician payments have remained nearly flat since the OHP began in 1994.

[1] The healthcare provider groups (or categories of service) referenced in this report include groups such as hospitals, physicians, mental health and dental providers. A full inventory of these "categories of service" is listed in the section entitled "OHP Payment Determination."

We are strong advocates of the Oregon Health Plan. We view it as a model which incorporates both innovative and realistic methods of providing appropriate health care to the greatest possible number of members. We believe, however, that the OHP will soon face a major crisis if payments to physicians are not raised to more reasonable levels.

In this report, we first recap the major findings in our past reports. We then discuss the various means by which physicians participate in the OHP since this has a significant impact on payment levels. We then review the methods used by the State of Oregon to determine payment levels and point out problems with the methodology. We next discuss what is occurring in Medicare payment trends between physicians and hospitals because this has a major impact on how OHP payments are calculated. We then show historic OHP payment trends to physicians. As in our earlier reports, we compare physician experience to hospital experience. We finish with our conclusions and comments.

RECAP OF FINDINGS - 1999 & 2001 REPORTS

Our last two reports, dated January 1999 and July 2001, focused on comparing physician compensation/reimbursement to hospital reimbursement. The significant findings were as follows:

- In FY 1999-2000, hospitals received 92.8% more revenue per discharge for Medicaid patients than in FY 1993-1994, when the OHP was first implemented. Physicians received on average 7% less per unit of service in FY 1999-2000 compared to FY 1993-1994.

- In FY 1999-2000, hospitals received OHP payments which were 73.9% of Commercial payments. Physicians received OHP payments which were 47% to 55% of Commercial payments, depending on withhold return experience.

- In FY 1999-2000, hospitals received OHP payments which were 95% of Medicare payments. Physicians received OHP payments which were 71% to 80% of Medicare payments, depending on withhold return experience.

- In FY 1999-2000, the average OHP RBRVS physician payment rate was $28.50 to $31.00. For one major plan in the Portland area, the RBRVS conversion factor was $24.95. This rate was comparable to the 1993 Medicaid fee-for-service payments used prior to the OHP implementation.

We reported the great disparity between OHP payments to hospitals and physicians, and we stated that all provider groups should share equally in discounting their services. We also concluded that the physician community had been willing to provide services at a lower rate than other OHP providers, but that many physicians would not tolerate a continued erosion of payments.

GENERAL STRUCTURE OF OHP PHYSICIAN PARTICIPATION

In assessing OHP payments to physicians, it is necessary to review the different ways physicians participate as OHP providers. This is important since physician reimbursement varies depending on the OHP payer and the type of contract entered into by the physicians. There are four general means by which physicians receive payments as OHP providers. Three of the four are through managed care organizations, called Fully Capitated Health Plans (FCHP). A FCHP contracts with the State to provide all healthcare services to those OHP members who sign up with the FCHP. FCHPs receive predetermined monthly allocations from the State for each of their OHP members; the FCHPs are thus considered to be fully-capitated.

The four categories are as follows:

1. **Medicaid Fee-For-Service Paid by the State of Oregon's Department of Medical Assistance Program (DMAP/FFS).**

   When services are provided to an OHP member who has not enrolled in a FCHP, the physician is paid directly from DMAP. DMAP has developed a payment system similar to the Medicare Resource-Based Relative Value System (RBRVS). DMAP uses its own conversion factor and has a fee schedule to determine payments for all physician services.

   About 94,500, or 26.2%, of all OHP members obtain services through DMAP/FFS.

2. **Fully Capitated Health Plan Fee-For-Service Contract (FCHP/FFS)**
   Under this payment system, a physician signs a contract with a FCHP and receives compensation on a fee-for-service basis for members enrolled in that FCHP. FCHPs use the Medicare RBRVS system to determine payment levels. The FCHP contracts contain a conversion factor which is used to calculate specific payments for all physician services.
   About 114,500, or 31.8%, of OHP members are enrolled in a FCHP/FFS.

3. **Fully-Capitated Health Plan Risk Contract (FCHP/Risk)**

   Under this payment system, a physician signs a contract with a FCHP and receives compensation on a FFS basis, minus a percent withhold. This withhold (typically 10%) is considered "at risk." This means that the withhold may or may not be returned to the physician at year end. The FCHPs use the Medicare RBRVS system to determine payment levels. The FCHP risk contracts contain a conversion factor which is used to calculate specific payments for all physician services.

   In these FCHP risk contracts, the physician's ultimate compensation is dependent on the amount of funds paid out by the FCHP each fiscal year. If there are funds remaining at year end, all or part of the physician's withhold will be returned. If all withhold is refunded and there are surplus funds available, additional compensation is often given to the physicians based on a pre-determined risk-sharing formula.

   About 131,500, or 36.5%, of OHP members are enrolled in FCHP/Risk contracts.

4. **Fully Capitated Health Plans - Special Categories**

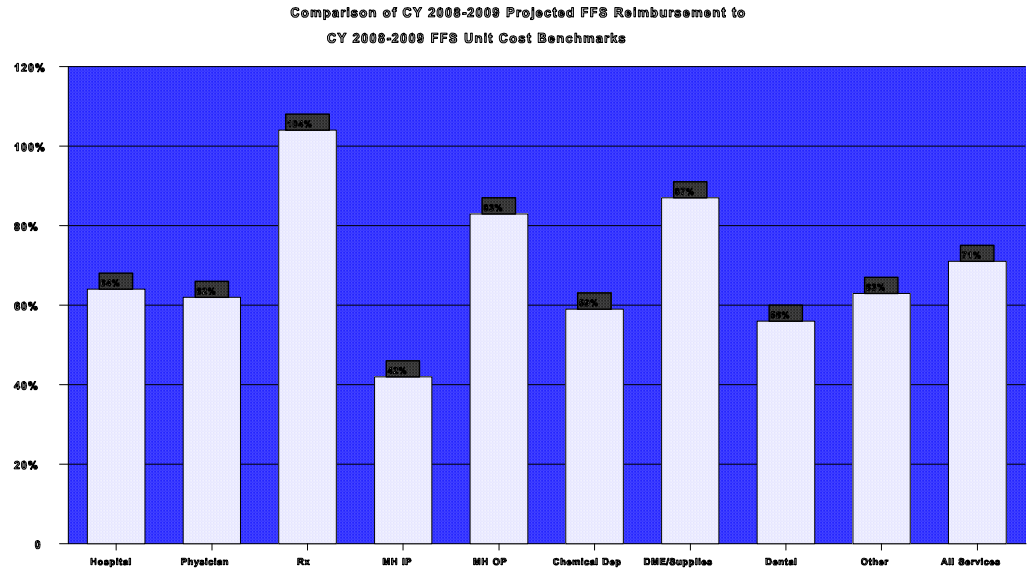
   Some physicians are employees of a healthcare system (i.e., Providence Health System) or are part of a closed HMO system (i.e., Kaiser). Provider compensation under these systems is determined internally, so compensation to these providers is not included in this study.

   About 20,000, or 5.6%, of OHP members are enrolled in these types of organizations.

OHP PAYMENT DETERMINATION

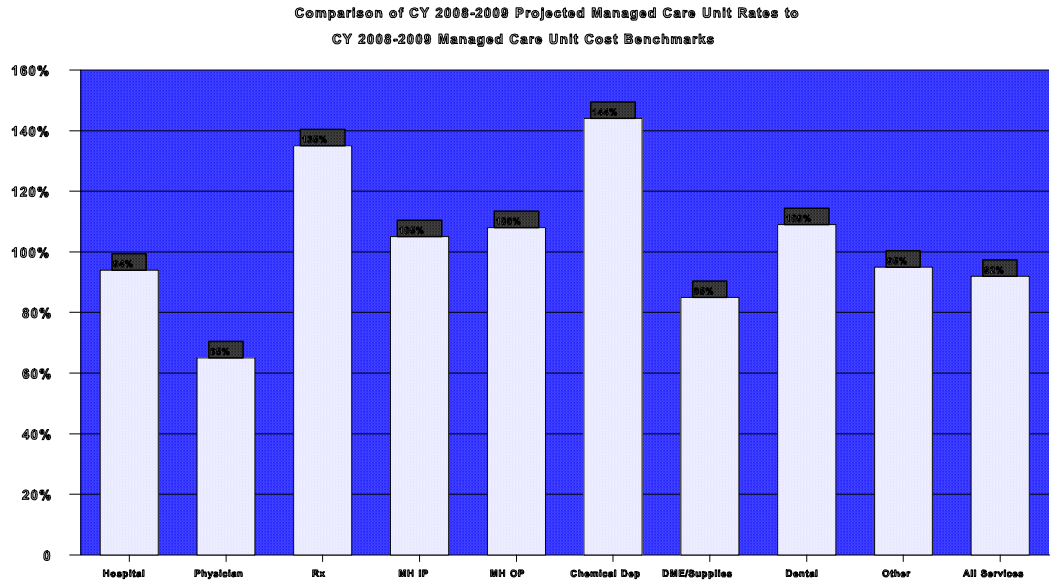
Since our earlier reports, the Oregon Health Services Commission retained Mercer Consultants and PriceWaterhouseCoopers to analyze data and recommend funding levels for the OHP. To ascertain funding levels, these consultants needed to determine the expected costs of twelve categories of service (COS). Those service categories include Hospital Services, Professional (Physician) Services, Prescription Drugs (Rx), Mental Health Inpatient Services (MH/IP), Mental Health Outpatient Services (MH/OP), Chemical Dependency Services, DME/Supplies, Dental Services, Home Health, Transportation, Vision, and Other. Using these expected cost estimates, Mercer produced "Benchmark" studies. The methodologies selected to determine the estimated costs for the Professional Services (i.e., physicians) are very problematic, which we explain below. Even if the methodology for Professional Services was not questionable, the Benchmark Study of March 2007 concludes that projected reimbursement to physicians for the calendar Year 2008-2009 would be 62% of the Mercer Unit Benchmark Costs. As the following illustrates, physician reimbursement would be proportionately below reimbursement to nearly all the other COS, and well below the average of 71% of Mercer's Unit Benchmark Costs for all service categories combined:

Source: CY 2008-2009 Benchmark Rate Study, Oregon Health Plan Summary Report, Mercer Government Human Services Consulting, March 2007.



When comparing Managed Care[2] Unit Cost Benchmarks to Projected Managed Care Unit Rates, the shortfall in physician compensation is more pronounced. Physician payment reimbursement would be only 65% of the benchmark costs, compared to an average of 92% for all other services.

Source: CY 2008-2009 Benchmark Rate Study, Oregon Health Plan Summary Report, Mercer Government Human Services Consulting, March 2007.



It is important to note that over 73% of OHP members are enrolled in a FCHP. Therefore, the above graph represents the majority of physician payments.

[2] When the term "managed care" is used by Mercer, it refers to all members who are enrolled in a FCHP.

MERCER BENCHMARKS - PROBLEMS WITH METHODOLOGY

The Mercer Benchmark Studies are based on methodologies and assumptions which must be challenged, specifically the cost-based approach in general and the formula used for determining physician costs in particular.

It has long been our position that using cost-based data to establish reimbursement rates, and thus funding levels, is not a sound methodology. The OHP has always relied on managed care organizations (FCHPs) to encourage appropriate utilization and cost control. Over 73% of OHP members are enrolled in a FCHP. ***Cost-based funding is the antithesis of managed care budget funding in that cost-based funding rewards the COS that consume more healthcare dollars. The service groups who most efficiently manage expenditures will be penalized in future years as funding levels are proportionately decreased.***

More troubling is the methodology used to determine physicians' costs. Mercer used the Average Market Reimbursement Approach to estimate physician cost levels. This methodology relies on an assumed payer mix, using Medicaid, Medicare, and Commercial payer rates to estimate costs. ***This method ensures a continuous reduction in OHP/Medicaid physician payments, due to the declining Medicare reimbursement and stagnant Commercial reimbursement to physicians.***

Medicare payments to physicians have declined over the past ten years, as shown in the section entitled "Medicare Payment Trends - Physicians & Hospitals."

Regarding Commercial payments, 2006 marked the first time since the mid-1990s that some Commercial payers in Oregon decreased conversion factors to physicians. The companies that increased payments did so minimally; almost without exception, increases were only one to two percent (1% - 2%). Consequently, the Mercer Benchmarks are being tied to payers who are cutting back fees (i.e., Medicare and some Commercial payers) or who are only slightly increasing fees.

MERCER BENCHMARK FINDINGS - HISTORICAL

Mercer Benchmark findings play a key role in establishing payment levels for the COS. As noted, the methodology used to determine physician costs is different from the methodologies utilized to determine other COS costs and ultimately results in lower payments to physicians.

The development of the Mercer Benchmark Unit Costs represents an attempt to quantify the cost of a unit of service provided by each COS. Methodologies used to determine what a unit of service is comprised of vary from COS to COS, and these methodologies are defined in the Mercer Benchmark Studies. The same methodologies are then used to establish the actual unit payment paid by the OHP. Thus, Mercer concludes, one can compare payments made per unit to each COS versus projected cost per unit for each COS (see table on next page).

Even without taking into account the questionable methodology used to estimate physician costs, physicians have been taking bigger discounts in recent years than all other COS with the exception of Mental Health Inpatient.

A comparison of the 2004 Mercer Unit Cost Benchmarks and the 2008-2009 Mercer Projected FFS payments illustrates the disparity in physician payments compared to other service categories in 2004:

MERCER UNIT COST BENCHMARKS BY CATEGORY OF SERVICE - FFS			
Categories of Service	***2004 Unit Cost Benchmark***	***2008-2009 Projected Medicaid FFS Reimbursement***	***% Difference between Unit Cost Benchmark & Medicaid FFS Reimbursement***
Hospital Services	$550.19	$413.30	(24.9%)
Physician Services	$95.61	$64.56	(32.5%)
Prescription Drugs	$58.40	$71.07	+21.7%
Mental Health Inpatient	$847.80	$429.24	(49.4%)
Mental Health Outpatient	$113.30	$112.95	(0.3%)
Chemical Dependency	$56.69	$39.35	(29.5%)
DME/Supplies	$1.69	$1.62	(4.1%)
Dental Services	$52.35	$36.72	(29.9%)
Other	$53.93	$37.77	(30.0%)
All Services	$35.93	$26.08	(27.4%)

Source: CY 2008-2009 Benchmark Rate Study, Oregon Health Plan Summary Report, Mercer Government Human Services Consulting, March 2007.

Of even greater concern is the overall amount of reimbursement Mercer projects physicians will receive when the Mercer Managed Care Unit Rates are compared to the Mercer Unit Cost Benchmarks. It should be noted that Mercer strongly suggests comparisons not be made between the FFS Unit Cost Benchmarks and Managed Care Payment Rates. Since 73% of OHP members are enrolled in FCHPs, we believe comparisons must be made and are especially useful when analyzing relative fairness of payments among the groups. Even if there are some shortcomings in the methodologies used to determine the Managed Care Unit Rates for each COS, the difference between the physicians' experience and all the other COS can not be ignored.

MERCER UNIT COST BENCHMARKS BY COS - MANAGED CARE			
Categories of Service	***2004 Unit Cost Benchmark***	***2008-2009 Managed Care Unit Rates***	***% Difference between 2004 Unit Benchmark & Managed Care Unit Rate***
Hospital Services	$418.61	$452.77	+8.2%
Physician Services	$82.67	$59.98	(27.4%)
Prescription Drugs	$25.93	$41.31	+59.3%
Mental Health Inpatient	$178.48	$226.98	+27.2%
Mental Health Outpatient	$77.39	$96.37	+24.5%
Chemical Dependency	$29.34	$48.69	+66.0%
DME/Supplies	$1.94	$1.89	(2.6%)
Dental Services	$51.17	$68.03	+32.9%
Other	$86.82	$93.89	+8.1%
All Services	$45.93	$49.01	+6.7%

Source: CY 2008-2009 Benchmark Rate Study, Oregon Health Plan Summary Report, Mercer Government Human Services Consulting, March 2007.

In sum, not only is the physician benchmark artificially low, the payment rate, compared to the physician benchmark, is the lowest among all the COS.

MEDICARE PAYMENT TRENDS - PHYSICIANS & HOSPITALS

OHP payments to physicians and hospitals from FCHPs are nearly always tied to Medicare reimbursement methodologies. This means that the hospitals are reimbursed using the DRG system for inpatient care and that physicians are reimbursed using the RBRVS system.

For physicians, each physician service, referenced by a CPT Code, is assigned a Relative Value Unit (RVU). Payment amounts are calculated by multiplying the conversion factor by the RVU. RVUs might change slightly from year to year, but the changes usually result in shifts among CPT Codes. Some RVUs may increase while others decrease. The net payment to physicians as a whole changes little, if any. A change in the conversion factor will impact all physician services and is the most useful and accurate method of tracking physician payment trends.

For hospital payments, FCHPs often negotiate a percentage of what Medicare would pay under their DRG, outpatient and ER payment methodologies. For physicians, a conversion factor is negotiated which is then applied to the RBRVS system to determine payments for medical services.

The table below represents conversion factors only; it does not include adjusters and reductions which actually decrease payments to physicians. In 1997 and 2007, work RVU adjusters were decreased by 8.3% and 10.0% respectively. In 1999, the combined effects of recalibrating practice expense and malpractice adjusters, the elimination of the work adjuster and annual CPT coding changes resulted in a -7.5% budget neutrality adjustment to the conversion factor. Minor negative adjustments also occurred in 1998, 2001, 2002, 2003 and 2006 due to budget neutrality reductions. The only year budget neutrality adjustments worked favorably to physicians was in 2000, when a positive adjustment of less than 1% occurred.

PHYSICIAN MEDICARE CONVERSION FACTORS		
Year	***Conversion Factor***	***% Change from Previous Year***
1997	$35.7700	+1.2%
1998	$36.6900	+2.8%
1999	$34.7315	(5.3%)
2000	$36.6137	+5.4%
2001	$38.2581	+4.5%
2002	$36.1992	(5.2%)
2003	$36.7856	+1.6%
2004	$37.3374	+1.5%
2005	$37.8975	+1.5%
2006	$37.8975	-
2007	$37.8975	-

Source: Federal Registers dated November 22, 1996, October 31, 1997, November 2,1998, November 2,1999, November 1, 2000, November 1,2001, December 31,2002, November 7,2003, November 15, 2004, November 21, 2005 and December 1, 2006.

From 1997 to 2007, the Medicare conversion factor has increased 5.9%, from $35.7700 to $37.8975. This represents an increase of a little more than one half of one percent per year for the past ten years. **However, when all work adjusters and budget neutrality adjustments are taken into account (as described in the previous paragraph), physician payments actually decreased by approximately 1% per year over the past decade.**

Conversely, hospitals have seen steady yearly increases in Medicare payments. Unlike physician Medicare payment trends, it is more difficult to track hospital trends. For hospitals, there is no common conversion factor. Rather, formulas are used to determine inpatient, outpatient and ER payments.

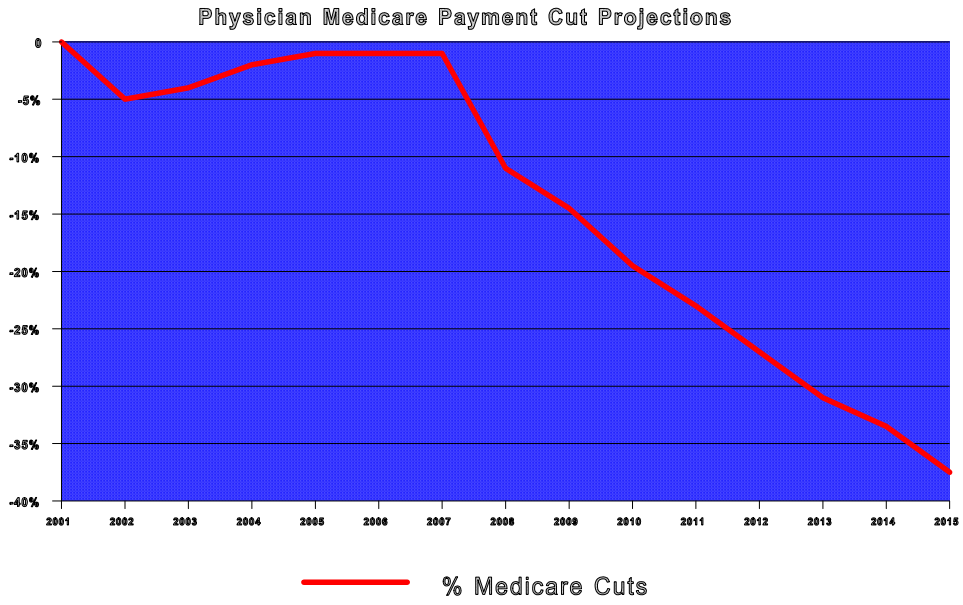
Medicare payment rates for hospitals are determined prospectively and are based primarily on historical costs. As a result, Medicare spending on hospitals has grown at a very high rate. Since

2000, the growth rate has been 8.3% per year for acute inpatient and outpatient services, which account for more than 90% of Medicare payments made to hospitals. About one half of this increase was due to increased volumes.[3] Cost per discharge (case mix adjusted) rose 5.4% in 2004 and 4.0% in 2005. Based on studies from CMS (Center for Medicare and Medicaid Services) and MedPac (Medicare Payment Advisory Commission), hospital payments on a per case basis have risen 4.0% to 5.0% per year over the past decade. Medicare per unit payments to hospitals over the past decade have thus increased 40% to 50%, compared to Medicare per unit payments to physicians, which have decreased about 10% over the same period.

[3] **Source: Report to Congress - Medicare Payment Policy, MedPac, March 2007.**

MEDICARE - FUTURE PAYMENTS

Future projections of Medicare reimbursement to physicians is disconcerting. The American Medical Association has projected that payments to physicians could be decreased by nearly 40% between 2007 and 2015.



Source: "Medicare Physician Payment Reform," American Medical Association, February 2007.

While this may be overstating the problem, there is a general consensus that Medicare payments to physicians will almost certainly decrease over the next several years. The only question appears to be how much they will decrease.

By tying OHP cost projections in part to Medicare reimbursement, physicians will continue to see flat or decreasing payment levels.

PHYSICIAN PAYMENT TRENDS - OREGON HEALTH PLAN

Based on low payment rates to physicians and higher payments to hospitals and other COS, it should not be surprising to find that physician payments in the OHP have been nearly flat since the plan was first implemented. As noted, the key indicator used to determine physician payments is the conversion factor which is multiplied by the RVU assigned to a specific physician service. A change in the conversion factor will impact all physician services and is the most useful and accurate method of tracking physician payment trends.

The conversion factor for physicians participating in the OHP, whether in a FCHP or on a fee-for-service basis has remained nearly the same since the OHP was first implemented in 1994. The following table shows the physician conversion factors between 2002 and 2007 for both types of FCHPs and for DMAP/FFS.

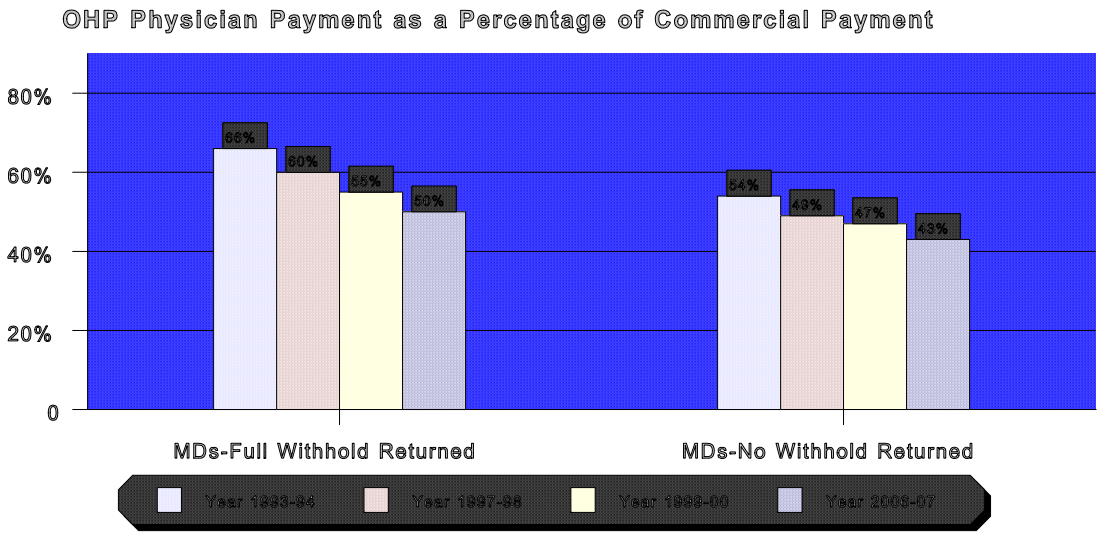
AVERAGE CONVERSION FACTORS - FCHP		
Year	***Conversion Factor FCHP***	***Conversion Factor DMAP FFS***
2002	$30 - $31	$25.95
2003	$30 - $31	$25.95
2004	$31 - $32	$25.95
2005	$31 - $32	$25.95
2006	$31 - $32	$25.95
2007	$32 - $33	$25.95

For FCHPs, this represents a 3.3% increase in payments over six years, or a little over one half of one percent per year. When the OHP was first implemented, the standard conversion factor used by FCHPs was $30.00. This translates to a percentage increase in payments to physicians of 5% over the last 13 years.

For physicians providing services to DMAP/FFS members, the conversion factor has been frozen at $25.95 for the past seven years.

PHYSICIAN OHP PAYMENTS VERSUS COMMERCIAL PAYMENTS

In 1994, the FCHP physician conversion factor was approximately 65% to 70% of the Commercial market conversion factors. Today, the FCHP physician conversion factor is about 50% of the Commercial market conversion factor.



The DMAP FFS conversion factor is about 40% of the Commercial market conversion factor.

SURPLUS PAYMENTS - IMPACT ON PHYSICIANS & HOSPITALS

Many of the FCHPs have risk-sharing arrangements with providers and/or hospitals. In the past, these arrangements have often resulted in withhold returns and surplus distributions to physicians and hospitals. The data regarding specific amounts paid out is proprietary and unavailable. These surpluses resulted in physicians and hospitals realizing higher payment rates than received strictly from their FFS payments.

Our experience has been that this surplus has encouraged physicians to continue to participate in the OHP. Based on information from several FCHP administrators, the surpluses for 2006 will be much less than in the past, and some FCHPs will have no excess funds to pay surpluses or even withhold returns. This appears to be due to last year's OHP budget cuts. This means that in most cases physicians who lose their withholds will realize conversion factors below $30.00.

DOLLARS SPENT BETWEEN HOSPITALS & PHYSICIANS

Managed care plans (Commercial and Medicare) generally budget expenditures between physicians and hospitals at or near 50/50. This means one could expect the total dollars paid to hospitals and physicians to be relatively comparable. In our 2001 study, we found that this was not the case with OHP expenditures. A disproportionate amount of dollars was paid to hospitals. That trend has continued in the last four years as illustrated by the following table:

Actual Dollars Paid by FCHPs[4]				
	2003	***2004***	***2005***	***2006***
Physicians	$152,704,577	$162,135,884	$174,251,894	$145,044,092
Hospitals	$206,756,634	$246,343,558	$266,072,121	$239,801,089

In our 2001 study, we found that the expenditure ratio was 43.0% to physicians and 57.0% to hospitals in the year 2000. The trend has been and continues to be consistent. The ratio between physicians and hospitals over the last four years has been as follows:

Percentage of Dollars Paid to Physicians & Hospitals - FCHPs[5]				
	2003	***2004***	***2005***	***2006***
Physicians	42.5%	39.7%	39.5%	37.8%
Hospitals	57.5%	60.3%	60.5%	62.2%

Note: These figures do not include additional payments to hospitals from other governmental sources, i.e., hospital wrap-around payments, disproportionate share hospital reimbursement and graduate medical education (both federally-mandated and state-mandated) payments.

[4] From Quarterly Financial Reports submitted to the Office of Medical Assistance Program at the Department of Human Services by all Fully Capitated Health Plans, as required by law.

[5] From Quarterly Financial Reports submitted to the Office of Medical Assistance Program at the Department of Human Services by all Fully Capitated Health Plans, as required by law.

DIVIDING THE DOLLARS

Another method used to track relative payment trends is to look at where the total dollars have been paid. We discussed unit payments in the section entitled "Physician Payment Trends - Oregon Health Plan," but that only provides part of the picture. Unit costs could go down, but if volume was to increase, total payments received could also increase.

The following table illustrates per member per month (PMPM) expenditures from 2002 to 2004. These figures were tabulated by Mercer and include all expenditures for FFS and FCHP, or 100% of OHP expenditures. 2006 data is not yet available.

PMPM EXPENDITURES - 2002 - 2004

COS	*2002*	*2004*	*% Change*
Prescription Drugs	$73.74	$83.56	+13.3%
Hospital Services	$67.43	$73.48	+9.0%
Physician Services	$48.91	$50.22	+2.7%
Mental Health - OP	$21.06	$21.92	+4.1%
Mental Health - IP	$4.83	$10.47	+116.8%
Dental Services	$15.99	$12.34	(22.8%)
DME - Supplies	$6.22	$6.59	+5.9%
Chemical Dependency	$5.66	$3.30	(41.2%)
Other	$13.54	$9.22	(31.9%)
TOTAL	**$257.38**	**$271.10**	**+5.3%**

Source: CY 2008-2009 Benchmark Rate Study, Oregon Health Plan Summary Report, Mercer Government Human Services Consulting, March 2007.

This table clearly shows that more and more OHP dollars are going toward prescription drugs and hospitals. Total expenditures increased by 5.3%. Payments to physicians increased by 2.7%, or about one-half the overall rate.

COMPARING PHYSICIAN & HOSPITAL PAYMENTS

A key question we are often asked is why compare physician reimbursement rates to hospital (and other COS) reimbursement rates. Each year, a finite amount of dollars is allocated to provide comprehensive health services to a projected number of beneficiaries. Those dollars are paid out to the various providers of health services. When payments to any group of providers increases, the other groups will experience a decrease in their payments.

The bigger question - whether an appropriate amount of money is being allocated for the healthcare needs of OHP members - is beyond the scope of this report. Rather, this report includes an analysis of the relative allocations of the total dollars earmarked by the OHP.

All provider groups are trying to obtain fair payment levels for the services they provide. Our data clearly illustrates, however, that hospitals are doing much better than physicians in regard to the compensation they are receiving from the OHP.

This is a volatile issue, and every report we published was aggressively challenged by the hospital industry. We responded to each of those challenges, citing all of our sources and we effectively defended our studies. Only one week after our January 1999 study was released, Milliman USA (formerly Milliman & Robertson) produced a similar study with almost the exact same findings.

PHYSICIAN PARTICIPATION IN OHP
COMMENTS/CONCLUSIONS

Our findings confirm what many physicians have expressed for the past several years. OHP payment rates to physicians have increased very little, if at all, since the OHP began in 1994. While most physicians take seriously their social obligation to provide care to Medicaid members, a point is reached when payments are so low that it may not be financially feasible to continue to do so. We believe many physicians have now reached that point.

The trends we have noted in this report regarding physician payments are all heading in a negative direction. It is imperative that some fundamental changes be made to assure adequate participation on the part of the physician community.

As consultants, we have consistently recommended to our physician clients that they should participate in FCHPs with shared risk. As opposed to FCHP/FFS, FCHP/Risk plans provide physicians with an opportunity to supplement a low conversion factor with surplus funds.

Based on the 2006 experience of FCHP/Risk plans, it appears that surpluses may not be available in the future. If they are available, they will almost certainly be much smaller than in the past and may have little impact on total payment.

As we stated in our introduction, we support the Oregon Health Plan. We have worked for and consulted with hospitals and physicians for the past 25 years, and we have advocated for the OHP since it was initially conceptualized.

We have also consistently maintained that to be successful, all parties involved must make comparable sacrifices. Our earlier studies showed that comparable sacrifices had not been made. Unfortunately, OHP payments to physicians have continued to remain stagnant resulting in a widening gap between OHP physician payments and OHP payments to the other provider groups.

EXHIBIT I

Changes in Medicare Reimbursement

Case Study - Spinal Fusion

The payment trends below illustrate the changes in Medicare reimbursement to hospitals and physicians for a spinal fusion procedure. From 2003 to 2007, Medicare payments to hospitals increased 37.6%. Medicare payments to physicians increased 2%.

This represents one specific procedure and is not necessarily representative of overall trends in Medicare payments.

Hospital Payments DRG 498[6] - Spinal Fusion						
2003	***2004***	***2005***	***2006***	***2007***	***Change***	***% Change***
$11,523	$12,217	$13,189	$14,318	$15,853	+$4,330	+37.6%

Source: Medtronic Sofamor Danek USA, Inc., Reimbursement Update, September 2006.

Physician Payments CPT Code 22800[7] - Spinal Fusion						
2003	***2004***	***2005***	***2006***	***2007***	***Change***	***% Change***
$1,250	$1,276	$1,313	$1,258	$1,275	+$25	+2.0%

Source: Federal Registers dated December 31,2002, November 7,2003, November 15, 2004, November 21, 2005 and December 1, 2006.

6 Assumes payment to a hospital with a wage index and geographic adjustment factor of 1.000.

7 Assumes no geographic adjustment.

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Presentation to the
Federal Laws Committee
of the Oregon Health Fund Board

Presented by Jane-ellen Weidanz

Director of Public Policy

Oregon Association of Hospitals & Health Systems

February 14, 2008

Oregon Association of Hospitals and Health Systems – Representing Oregon's Community Hospitals

Overview

- Medicare
- Medicaid
- Policy Recommendations

Medicare and Medicaid

- **Medicare and Medicaid policies and payments directly impact health care in Oregon.**
- **Combined, Medicare and Medicaid cover more than 30% of Oregonians with insurance**

Medicare and Medicaid

- **Medicare and Medicaid drive Oregon health care by setting:**
  - **Policies,**
  - **Populations covered**
  - **Funding, and**
  - **Payment level.**

Medicare and Medicaid

- Medicare is a federal program
- Congress establishes policy and funding levels
  - MedPAC advises Congress on policies, reimbursement and financing
- CMS sets rates and implements policies

Medicare overview

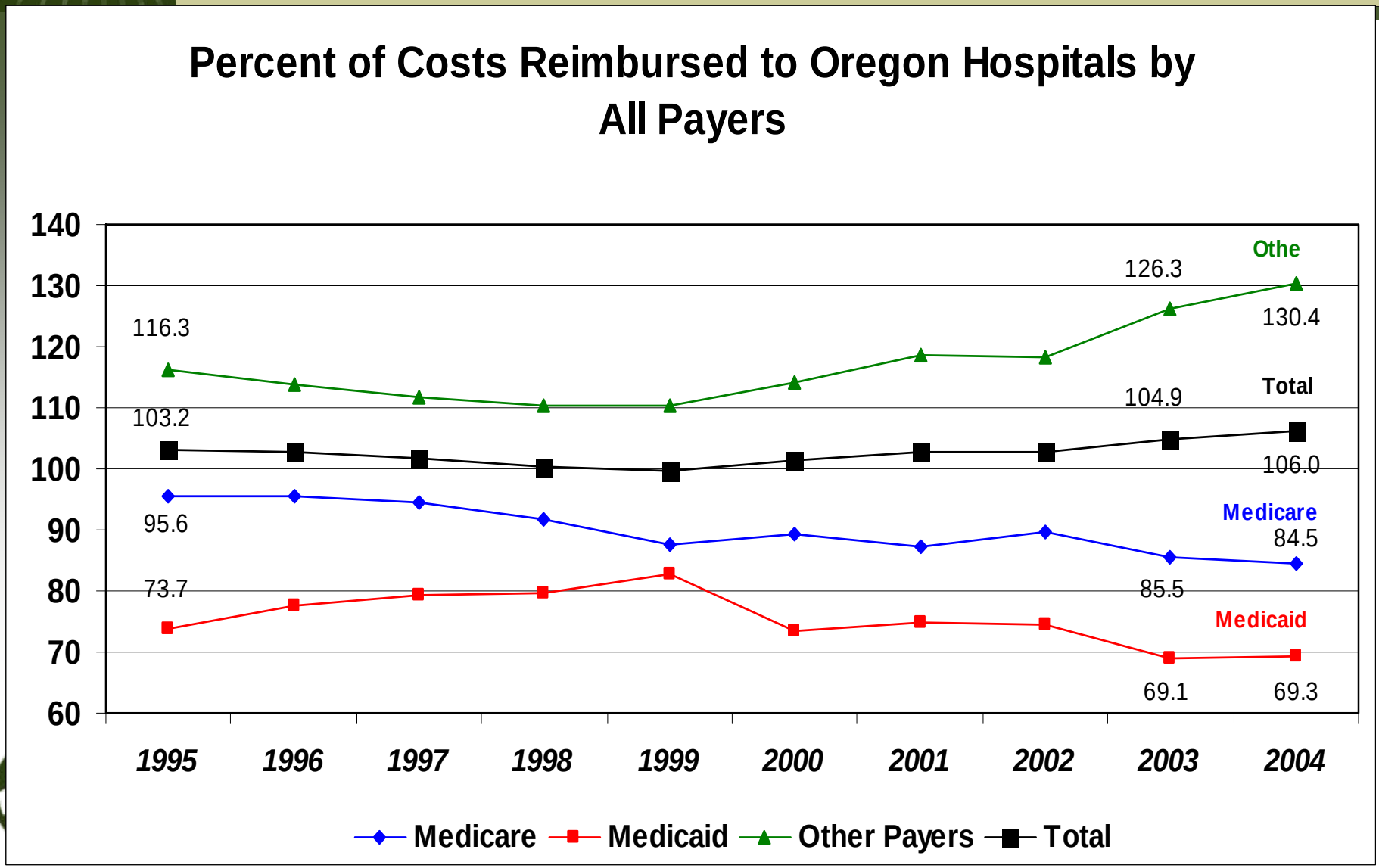
- **Medicare covers two different populations**
  - **Most individuals > 65**
    - 452,000 Oregonians (86% of beneficiaries)
  - **Many people with disabilities < 65**
    - 75,000 Oregonians (14% of beneficiaries)

Data Source: CMS 2004 State Statistics

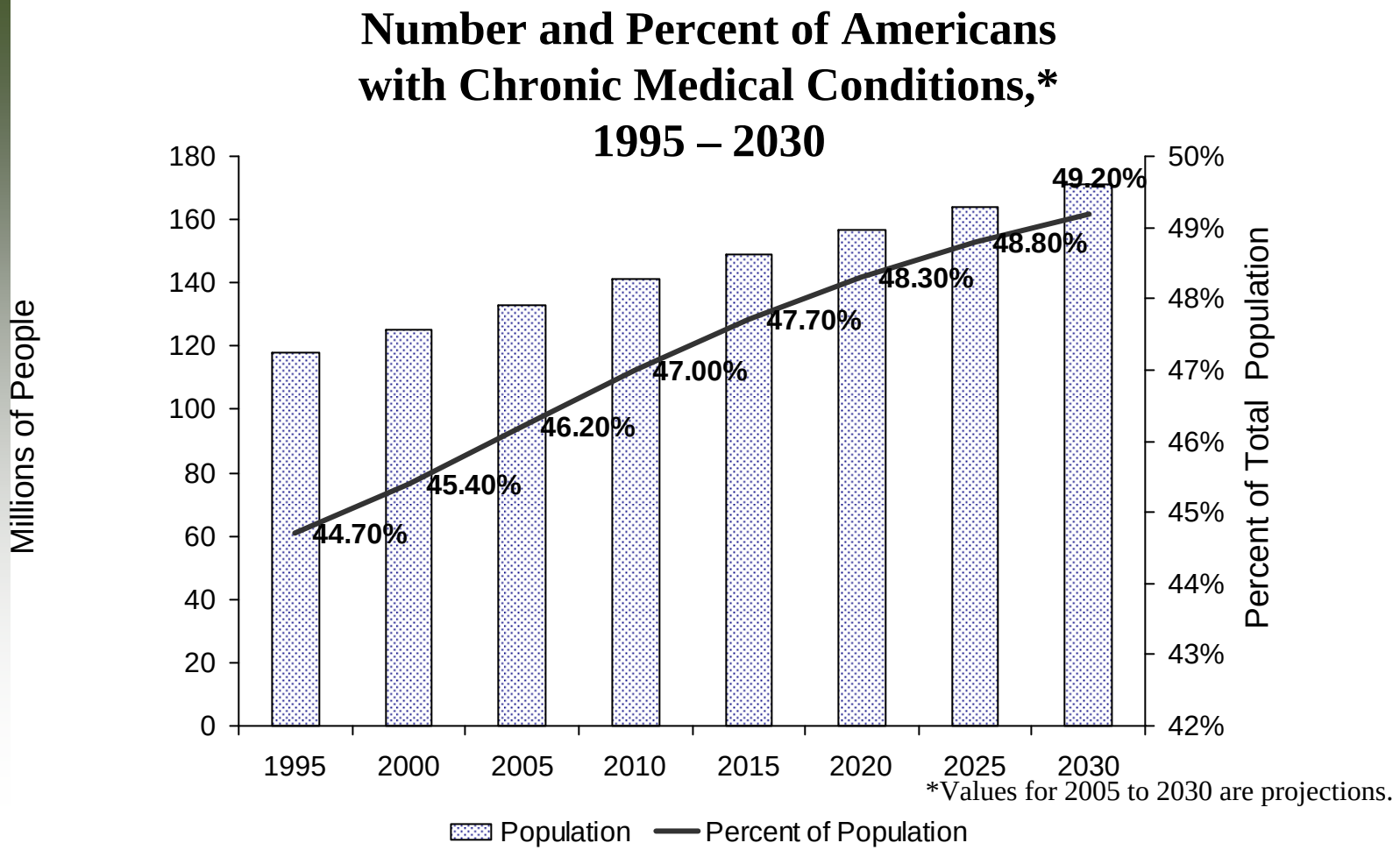
Medicare Concerns

- Hospitals must accept Medicare's payment rates – not negotiable.
- Payments do not cover full cost of care
- On average, Oregon hospitals are paid 81% of costs by Medicare.
- This results in a $513 million shortfall per year.
- Rate formula disadvantages cost effective states

Impact of Chronic Underpayment

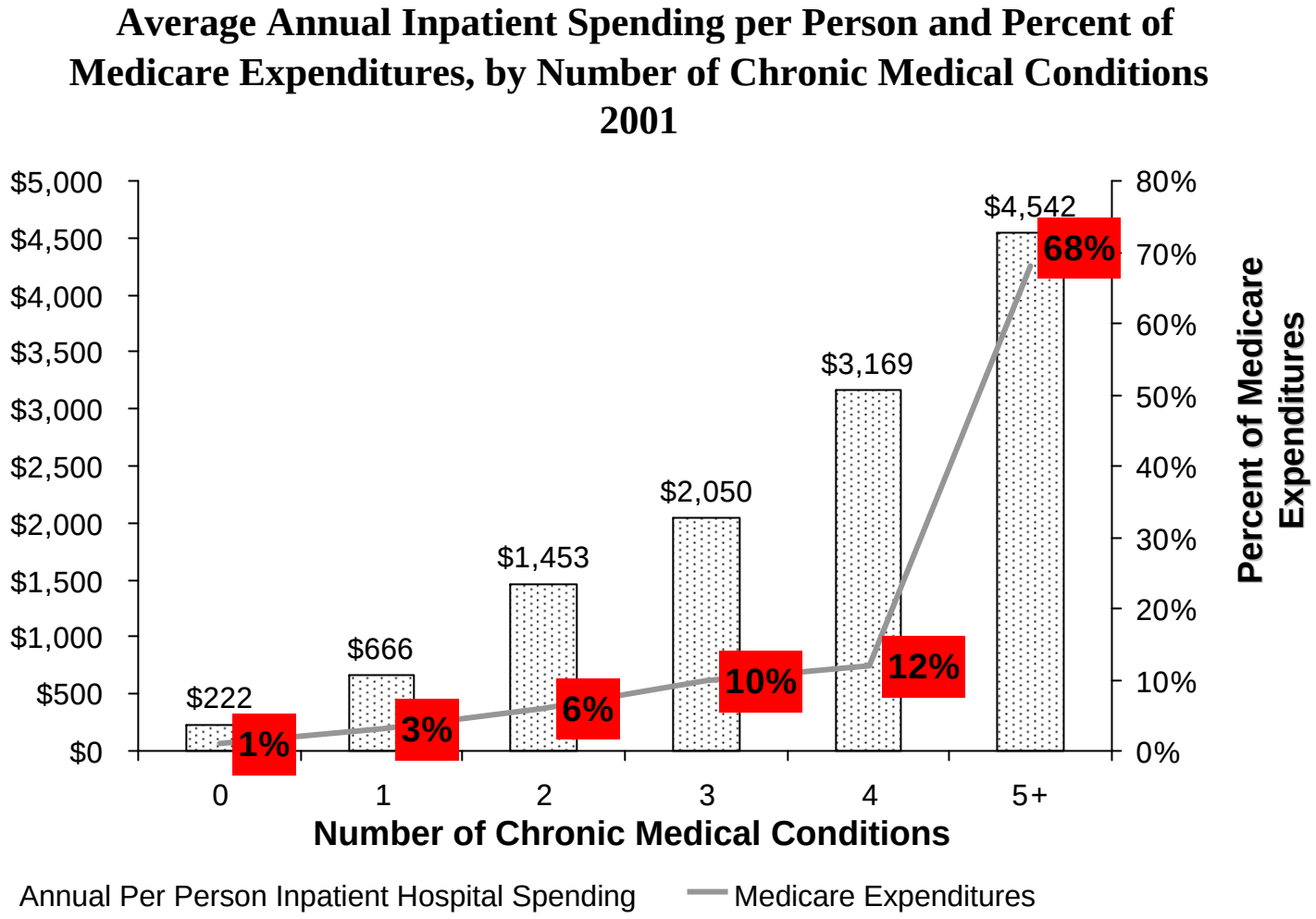


Drivers Medicare and Medicaid Costs



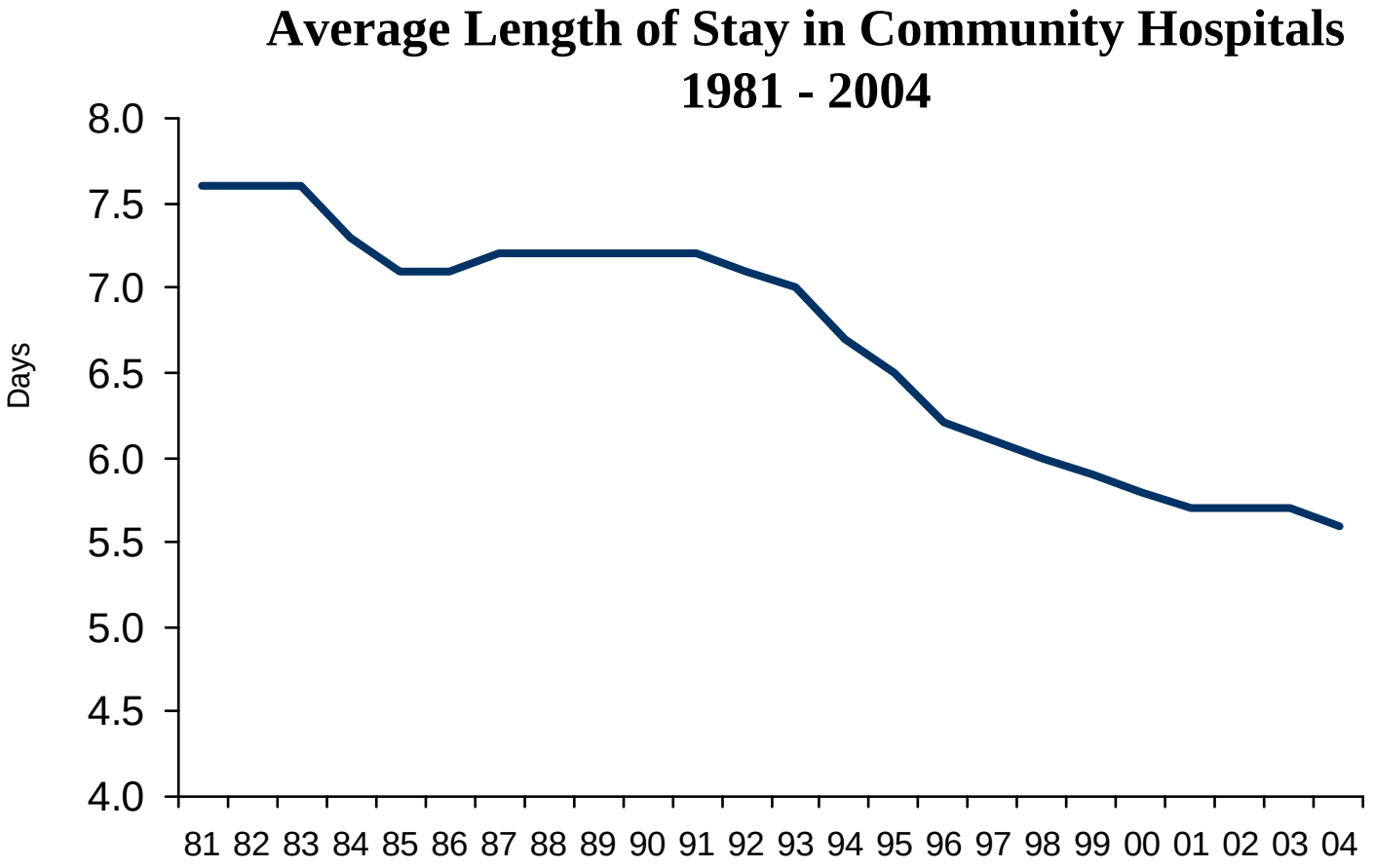
Source: Adapted from Partnership for Solutions, Johns Hopkins University, *Chronic Conditions: Making the Case for Ongoing Care*, December 2002

Impact of Chronic Conditions



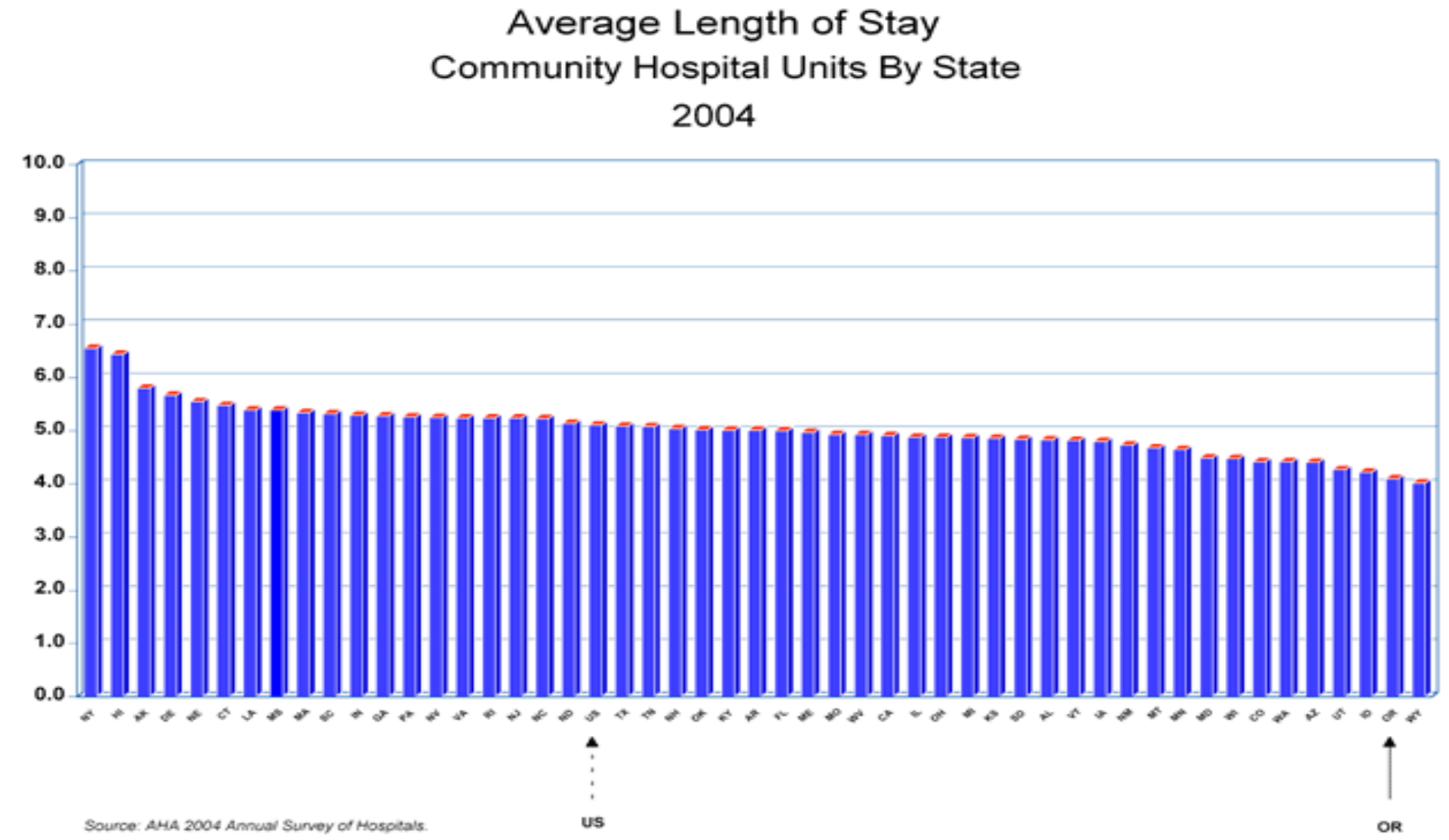
Source: Adapted from Partnership for Solutions, Medicare Expenditure Panel Survey, 2001, *Chronic Conditions: Making the Case for Ongoing Care*, September 2004

PPS and managed care led hospitals to reduce length of stay…

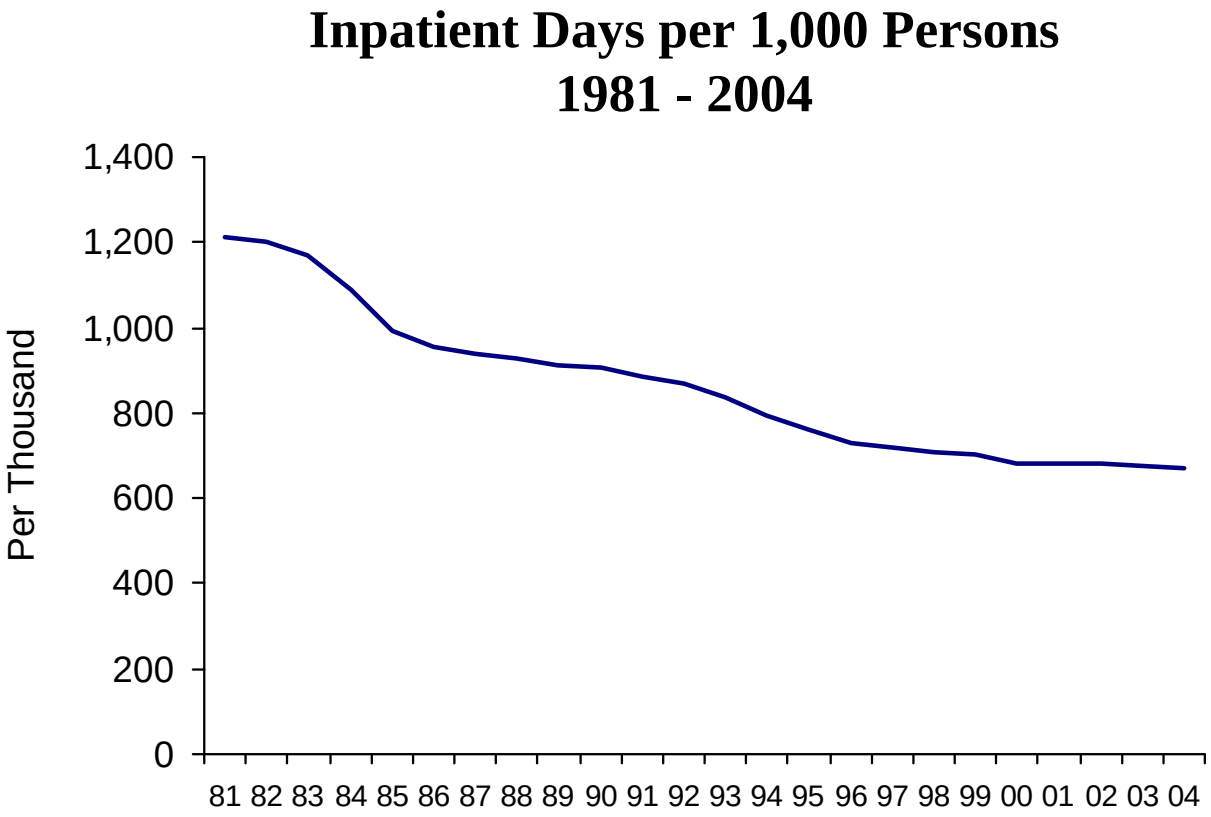


Source: The Lewin Group analysis of American Hospital Association Annual Survey data, 1981 – 2004, for community hospitals

But Now What?

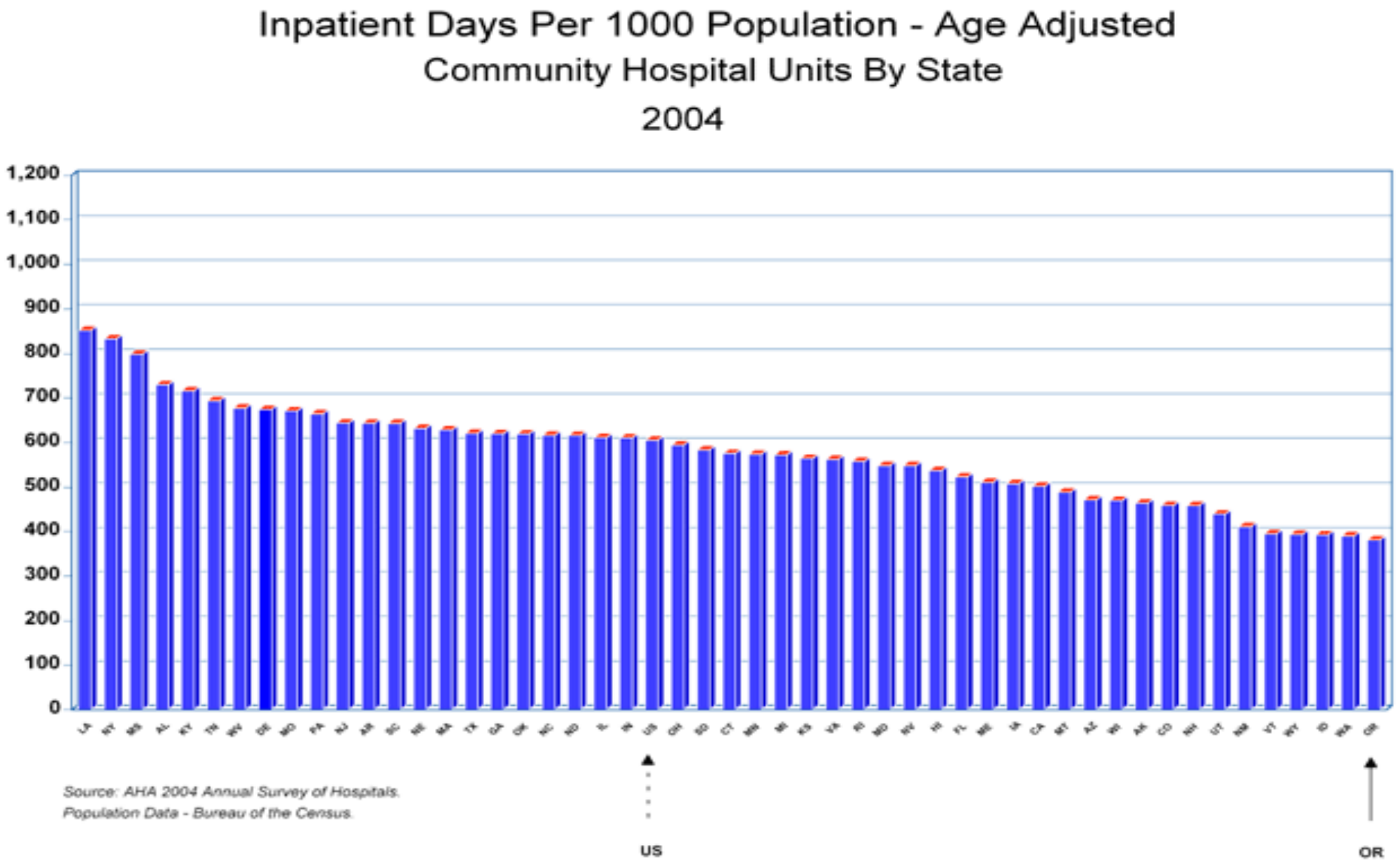

Average Length of Stay
Community Hospital Units By State
2004
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
US
OR
Source: AHA 2004 Annual Survey of Hospitals.

…PPS and managed care reduced hospital utilization rates



Source: AHA Statistics

But now what?


Inpatient Days Per 1000 Population - Age Adjusted
Community Hospital Units By State
2004
1,200
1,100
1,000
900
800
700
600
500
400
300
200
100
0
Source: AHA 2004 Annual Survey of Hospitals.
Population Data - Bureau of the Census.
US
OR

Medicaid

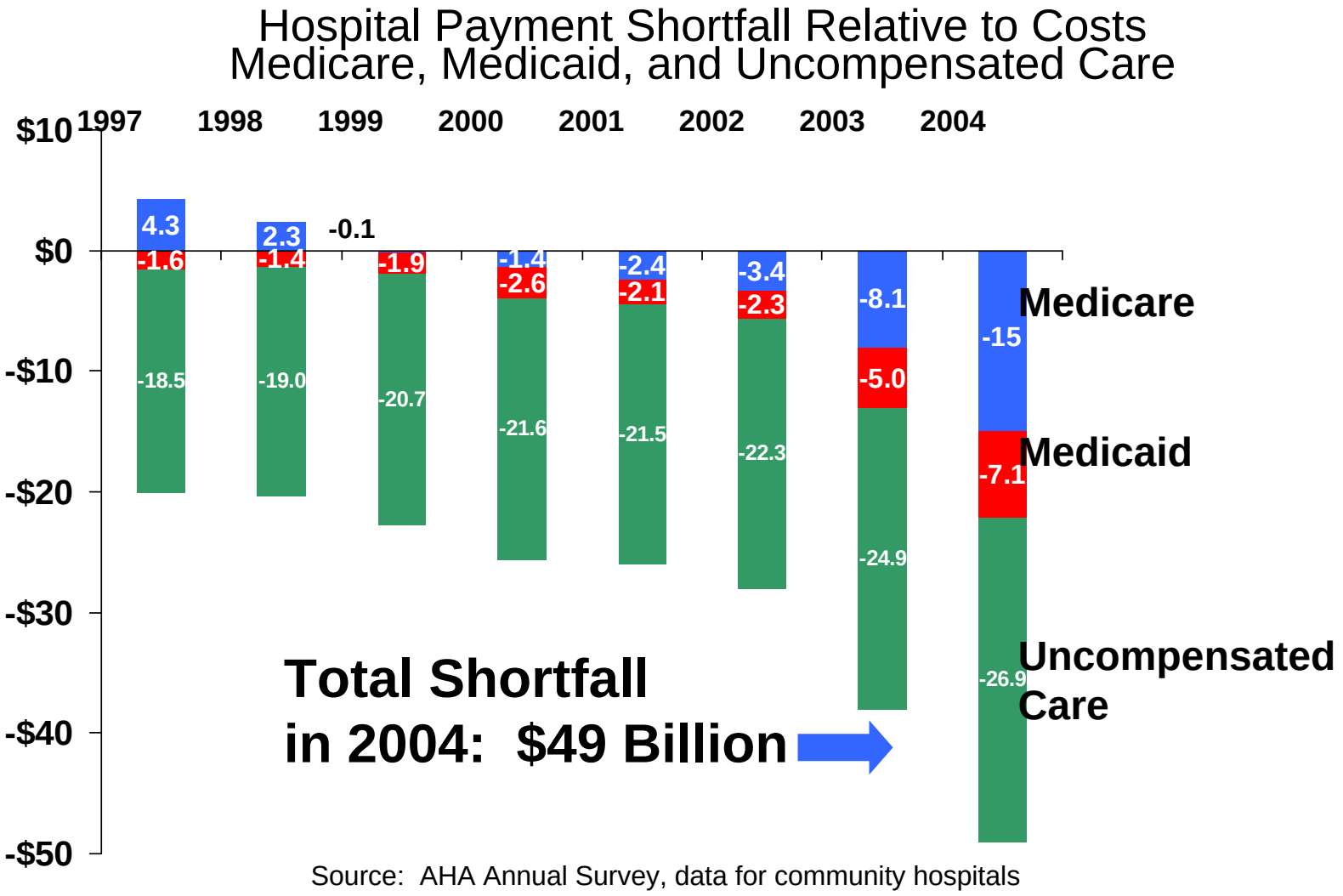
- **Federally mandated Categories of eligibility – OHP Plus**
- **Covers more than 347,000 Oregonians**
  - **Low income Children – 40%**
  - **Low income adults and families – 34%**
  - **Seniors, people with disabilities – 27%**

- **State Expansion - OHP Standard**
  - **State funding eliminated in 2003**
  - **Solely funded by Medicaid managed care and hospital provider taxes**
  - **Budgeted to cover 24,000 down from 100,000**
  - **Taxes sunset September 2009 because of federal law.**
- **No replacement funding has been identified.**
- **Lack of replacement funding endangers the entire OHP waiver program.**

Medicaid Concerns

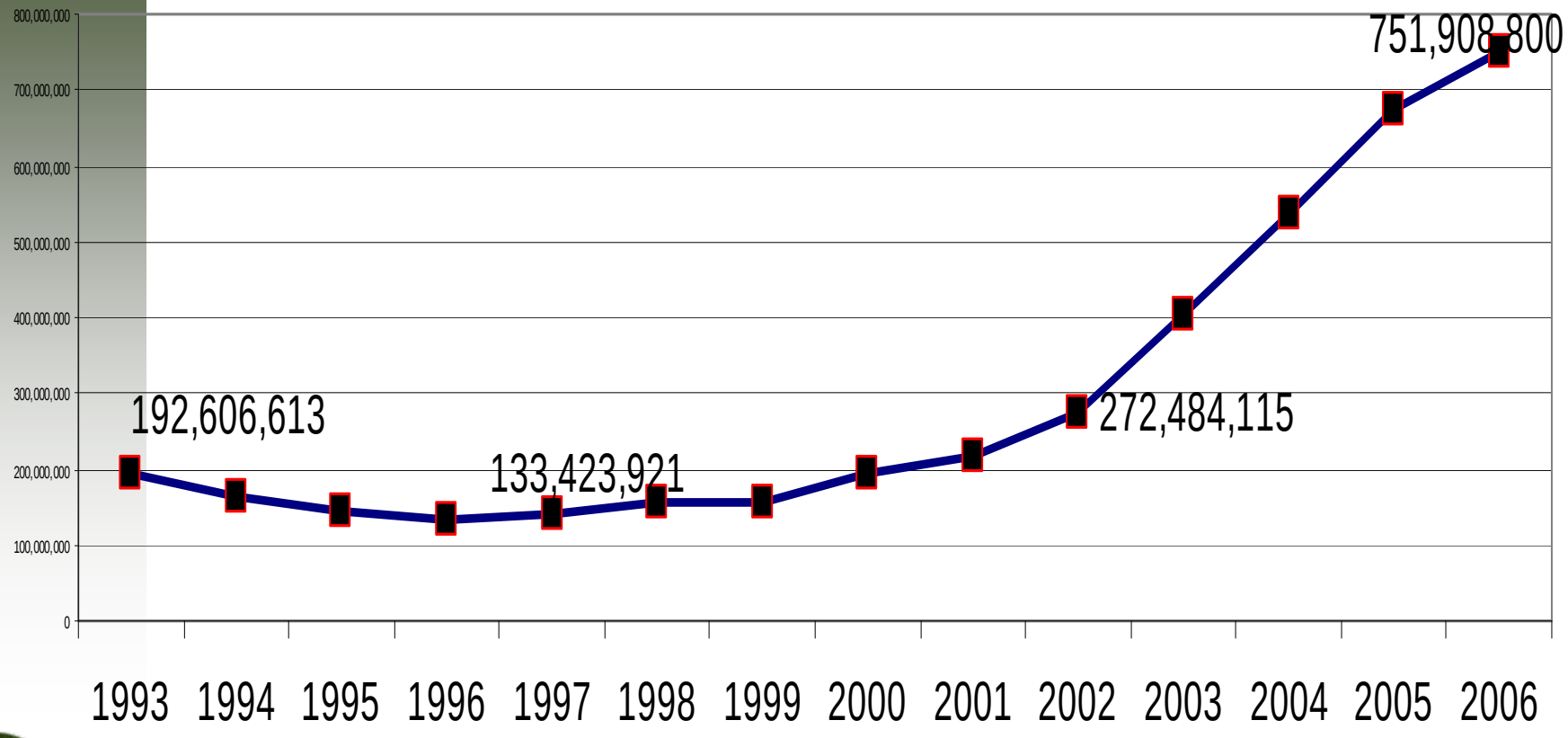
- **Medicaid Managed Care Plan reimburse hospitals at 80% of Medicare**
  - **So every $100 of costs**
    - Medicare would reimburse at $81
    - Medicaid Plans would reimburse at less than $65
- **Medicaid Fee-For-Service pays even less**
- **Oregon's history has shown dramatic cuts in:**
  - **Reimbursement rates**
  - **Covered populations**

Financial Shortfalls



Source: AHA Annual Survey, data for community hospitals

Oregon's Uncompensated Care



Policy Change Recommendations

- **If Congress raised Medicare rates for states like Oregon to the national average, we would:**
  - **Improve access to primary care;**
  - **Reduce cost-shift to other payers.**
- **If CMS encouraged states' efforts to expand coverage for the uninsured, we would see:**
  - **An easier, more flexible process for approval of waivers**
  - **More flexibility to use different revenue sources**
  - **States able to use SCHIP to the fullest extent**
  - **Consistent policies across states in waiver allowances**
    - If its good for state y, it should be good for state x.

Safety Net Clinic/FQHC Overview

Presentation for the Oregon Health Fund Federal Laws Committee

February 14, 2008

About the Oregon Primary Care Association (OPCA)

- Association for Safety Net Clinics
- Primary members are Community Health Centers
- OPCA provides:
  - Advocacy
  - Technical Assistance

2

Federally Qualified Health Centers

- 330 funded Community Health Centers AND
- Indian Health Clinics
- An Indian Health Clinic can also apply for and have received 330 funding

3

What is a CHC?

- Five Basic Characteristics:
  - Located in high need areas (MUA/P)
  - Governed by community boards (51% patients)
  - Comprehensive primary care/enabling services; also connect patients to specialist/hospital care/social services
  - Open to all residents regardless of ability to pay
    - Discount on costs (sliding fee scale):$37 million in 2006
  - Held to strict performance/accountability measures: administrative, clinical, governance, and financial
- Established through community collaboration

4

Benefits for FQHCs

- Access to federal $$$ to serve the uninsured (less than 50% of uninsured cost)
- Access to 340B pricing/Pfizer Sharing the Care Program
- Access to Federal Tort Claims Act Coverage
- Access to enhanced Medicaid/Medicare reimbursement

5

Community Health Centers in Oregon 2006

- Served over 238,000 Oregonians with over 1,000,000 medical, dental and mental health/substance abuse visits
- Of the patients that reported, 36% Hispanic/Latino, 4% African American, 2% Native American, 2% Asian/Pacific Islander
- Payor Mix
  - 47% uninsured - 13% private insurance
  - 34 % Medicaid - 6% Medicare
- Nearly 1/5 uninsured Oregonians are seen at HCs (19.5%)
- Over 1/5 Medicaid beneficiaries are seen at HCs (22%)
- About 95% of patients under 200% Federal Poverty Level

6

CHCs Meeting Unmet Need

- Serve those that need care the most
  - Cultural
  - Language (30% best served in another language)
  - Transportation
  - Geographic
  - Homeless
  - Higher prevalence of mental illness
  - Substance abuse
  - Cognitive impairment
  - Decreased functional status
  - Health literacy barriers
  - Socially isolated
  - Financial barriers

7

Where CHCs are located in Oregon

- 26 CHCs in Oregon with over 150 sites
- Located in 27 counties
- Most CHCs have a site in a rural area; we have sites in 4 of 10 designated frontier counties
- Coastal locations – Astoria, Lincoln County, Tillamook County, Coos Bay
- Up and down the I-5 corridor
- Central Oregon – Prineville, Madras, Bend
- Northeast Oregon – Hood River, Dalles, Boardman, Hermiston
- Eastern Oregon – Valle, Nyssa, Ontario

8

Federal Barriers

- Primary care in general: visit based payment from Medicaid and Medicare is flawed
- Medicare and Medicaid need to align their focus P4P vs. ratcheting back costs for cost effective perfomrance
- 1115 Waiver:
  - Community input should be an expectation from the development of the waiver to input once completed
  - Federal response to state Waiver requests need to be less onerous/more timely

9

Federal Barriers (Cont'd)

- Citizenship documentation barriers
- HPSA/MUA & P
  - Outdated system that needs to be updated particularly to reflect the needs of the safety net
  - Indicators used aren't favorable for the West Coast
- FQHC specific
  - Overall, 330 law is pretty good
  - There are specific adjustments needed that may be too detailed for this committee (e.g., FTCA for volunteers)

10

Oregon's Safety Net: Rural Health Clinics and Isolated Rural Health Facilities

Scott Ekblad, Director
Oregon Office of Rural Health
Oregon Health & Science University

OREGON ORH OFFICE OF RURAL HEALTH

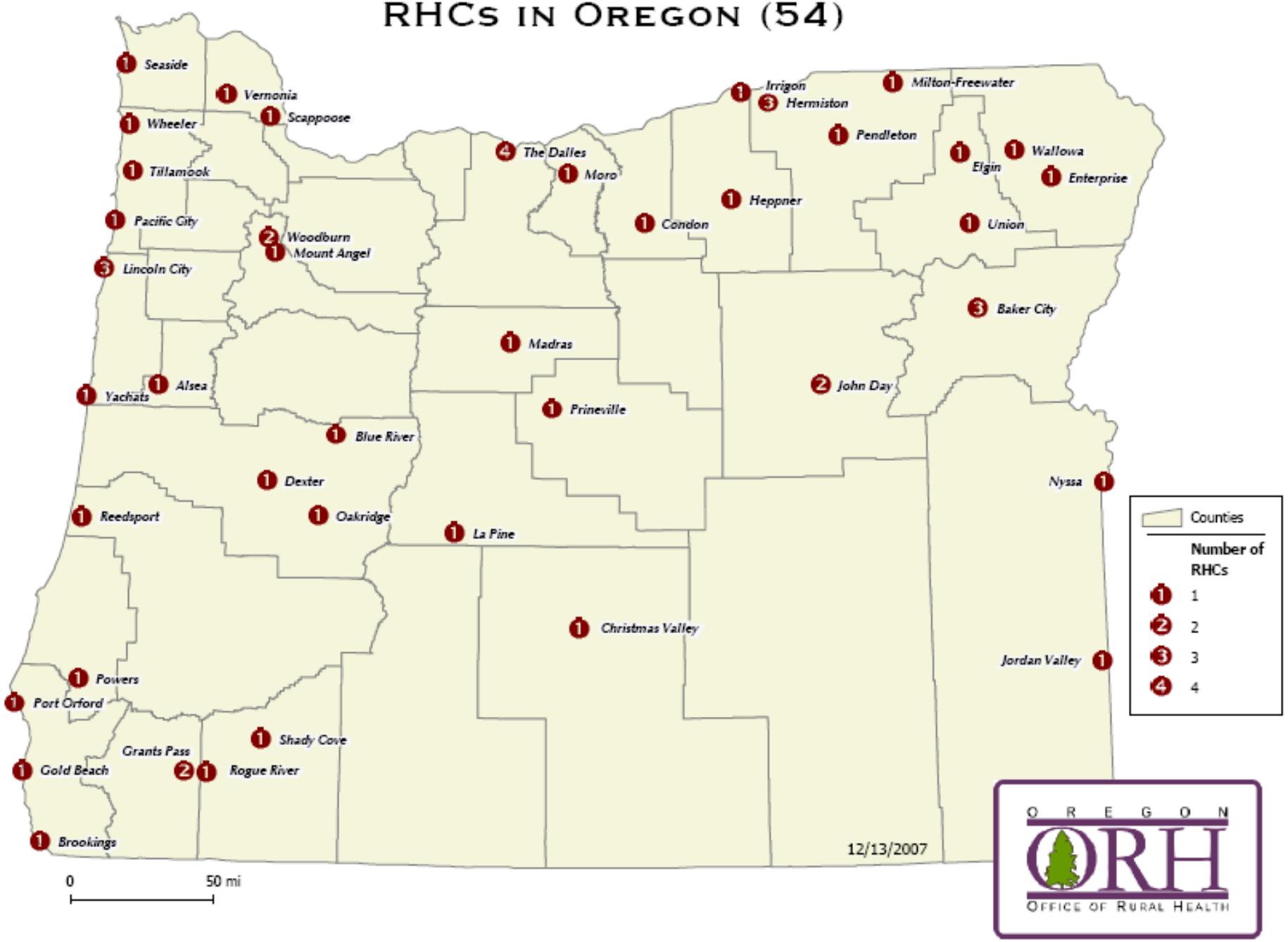
Rural Health Clinics

Rural Health Clinics are:

- Federally certified
- Located in a rural area
- Provide primary care services
- Located in Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs)
- Utilize a mid-level practitioner (NP or PA) at least half of the time the RHC operates

RHCs receive enhanced reimbursement from Medicare and Medicaid

RHCs in Oregon (54)



OREGON ORH OFFICE OF RURAL HEALTH

www.ohsu.edu/oregonruralhealth

Isolated Rural Health Facilities: a subset of Rural Health Clinics

- Historically, Oregon's federally certified Rural Health Clinics were characterized by geographic vulnerability and small patient populations

- More favorable reimbursement and an increase in HPSAs and MUAs enabled a doubling of the number of RHCs (currently 54)

- The Office of Rural Health created a new category of safety net RHCs – the Isolated Rural Health Facility.

Isolated Rural Health Facilities

IRHFs are:

- Federally certified Rural Health Clinics
- Private non-profit or public
- Located in rural communities
- Sole source of primary care in the community

Isolated Rural Health Facilities

Isolated Rural Health Facilities

- "Isolated Rural Health Facility" is currently a conceptual designation; no benefit is accrued by virtue of being an IRHF

- Should subsidies or other benefits for IRHFs be proposed, formal designation criteria could be developed

- The Office of Rural Health could provide the technical assistance necessary to meet these qualifications and maintain their IRHF designation

Federal Laws Affecting RHCs

- Initial payment limit for RHCs established in 1988 at $46 per visit
- Annual increases thereafter based on Medicare Economic Index
- Currently $76 per visit
- ***Raise RHC payment cap to at least $90 per visit***

Federal Laws Affecting RHCs

- Medicare rule currently allows reimbursement for mental health services provided only by LCSWs or clinical psychologists

- ***Expand the types of mental health providers able to provide services to RHC patients***

Federal Laws Affecting RHCs

Productivity guidelines for health care staff are used to determine payment for services.

Productivity standards are outdated and should be eliminated or, at a minimum, revised.

Thank You

Scott Ekblad

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www.ohsu.edu/oregonruralhealth

Additional comment emailed 2/15/08 from Scott Ekblad, Director, Oregon Office of Rural Health:
If you go to page 14, 40.1 states that certain services, including health/wellness promotion activities, are not allowable. We would like them to be, for both RHCs and FQHCs. We would also like any barriers removed that prevent integration of dental, hearing, vision, mental health, etc. services.

EXCERPT FROM: Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers

40.1 - Costs Excluded from Allowable Costs (Rev. 1, 10-01-03) RHC-501.1

Items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations are not allowable. Preventive primary physical examinations targeted to risk are allowable at FQHCs.

Items and services that are covered under Part B of Medicare, but are not included in the definition of RHC/FQHC services, e.g., routine diagnostic and laboratory services, independent laboratory services, durable medical equipment, and ambulance services are not allowable on the cost report. However, the provider of these services may bill for these items separately.