Access to Health Care in Oregon

Office of Health Policy & Research
DHS Office of Health Systems Planning
Oregon Primary Care Association

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Access

Working Definition:

"Timely patient contact with appropriate providers of needed health services."

- **Timely, for effective prevention and early diagnosis and treatment**
- **Appropriate provider, for cultural/linguistic competence and suitable clinical skills**
- **Needed services, for appropriate cost-effective care in an appropriate setting to improve the health status of the population served.**

Access
Why Should We Care?

- Access correlates with
  - Quality of care and health outcomes
  - Cost of care and cost shifting within the overall health care system
  - What the state and other purchasers of care can buy within budget limits: value per health care dollar spent

Impact of Access Problems on Health Outcomes and Cost

- When access is compromised, health outcomes worsen due to factors such as late diagnosis and missed treatment opportunities.
- Often, the result is worse outcomes at higher costs, as when untreated hypertension leads to stroke, or untreated diabetes leads to amputation or blindness.

Prevalence of Access Problems

- Access problems affect Oregonians who are
  - Uninsured (approximately 14% of total pop.)
  - Under-insured ?
  - Medicaid 12%
  - Medicare 12%
  - Members of racial and ethnic communities 10%
  - In rural and “frontier” areas ?

Access and Cost

- When costs rise, access tends to be reduced unless revenues increase enough to bridge the gap.
- When costs rise and revenues do ***not*** increase to bridge the gap, uncompensated care limits access to appropriate care.

Access and Cost

- OHP Model: Access to care depends on three factors:

1. Inclusion – extend basic coverage to all
2. Payment – pay enough to cover the cost of care
3. Benefits – adjust covered benefits to fit the resources available

Access and Cost
Continued

- If all are not included, uncompensated care and cost shifting will increase
- If payments are not sufficient to cover the cost of care, (again) uncompensated care and cost shifting will increase
- If benefits cannot be reduced to meet budget limitations, then people will lose coverage, or payments will be reduced, or both.

Access and Cost
Continued

Bond's Proposition (Ross Bond, VP Safeco Insurance, circa 1980)

"Access, Cost, Quality ….

Pick Any Two."

Impact of Access Problems on Uncompensated Care

- When barriers to outpatient care lead to an emergency admission, hospitals face uncompensated care costs in the form of charity care or bad debt.
- When access to care is incomplete, missed appointments or unfilled prescriptions can lead to unnecessary and uncompensated physician care.

Impact of Access Problems on Uncompensated Care

continued

- The dollar value of uncompensated care in Oregon is difficult to determine.
- However, the impact of uncompensated care is significant as costs to "paying customers" increase, contributing to the fact that health insurance and health care become unaffordable.

Access and Insurance

- Access tends to increase with expansion of health insurance coverage.
- Insurance coverage doesn't guarantee access (although lack of insurance tends to increase access problems due to financial barriers)
  - An OHP "open card" may mean a difficult search for providers willing to see the patient
  - Private insurance may mean limited provider choice, especially for new patients

Access and Insurance

Continued

- The uninsured, especially those with lower incomes, tend to rely on the safety net for access. Safety net providers often take steps to address specific barriers to access: poverty; cultural/linguistic differences, geographic remoteness, etc.

Recent Experience with Insurance Levels in Oregon

- In the mid-90s, health coverage increased across the board as the OHP increased Medicaid enrollment by more than 100,000 and an even greater number of Oregonians gained coverage through expansion of employer-sponsored insurance. Uninsurance overall dropped from 18% to 11%, and for children from 21% to 8%.

Recent Experience with Insurance Levels in Oregon

- Today, erosion of employer-sponsored insurance is increasing the number of Oregonians who are uninsured, and increasing the demand for OHP coverage.
- Simultaneously, the OHP is contracting due to policy changes and tightening budget constraints.

Uninsurance and Providers

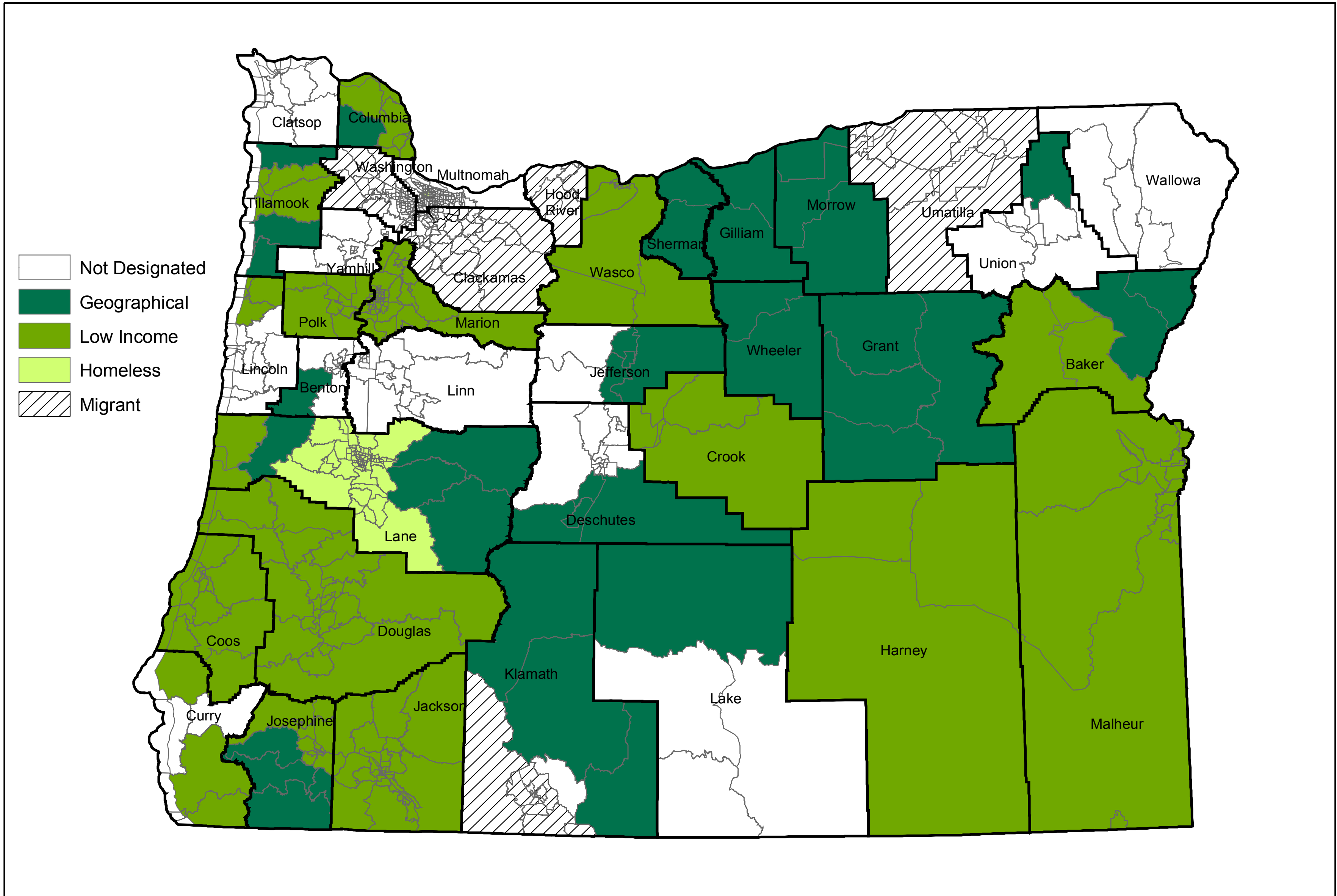
- With both private insurance and the OHP contracting, the burden on the safety net is increasing as more uninsured seek access through safety net providers.
- Mainstream providers who continue to see patients who have lost insurance stand to see increases in uncompensated care

Access and Capacity

- Providers are not distributed to match patient need in all areas of the state
- Provider capacity – the ability of the available providers to see patients in need of care – is inadequate in many areas of the state.
- Inadequate capacity is a barrier to access to needed care.

2004 Oregon Health Professional Shortage Areas (HPSA)

Primary Care Designations



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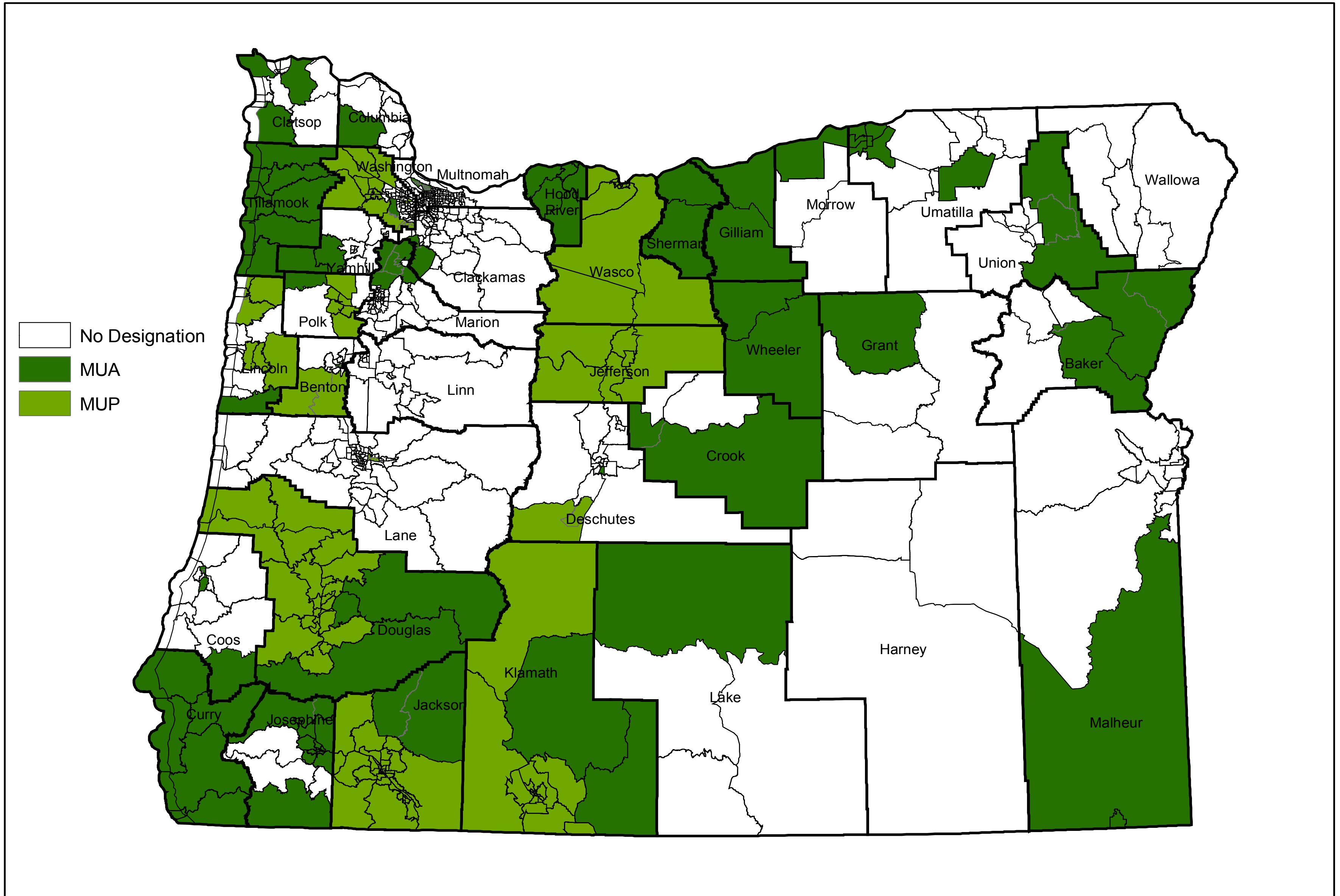
2004 Oregon Medically Underserved Areas & Populations



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Health Care Safety Net
Purpose

- The health care safety net is made up of those providers who meet the needs of vulnerable populations facing barriers to needed care. Barriers can be financial, cultural/linguistic, geographic, or related to health status (e.g., chronic mental illness).

Health Care Safety Net
Overview

- Includes a broad range of organizations, including local non-profits, government agencies and individual providers and facilities
- Providers do not turn patients away because of inability to pay

Health Care Safety Net
Overview

- A substantial share of safety net patients are uninsured, Medicaid, Medicare & other vulnerable populations
- Services vary, depending on mission and target populations
- Funding streams are diverse, including federal grants, Medicare, Medicaid, private insurance, and patient fees

Health Care Safety Net
Typical Services

- Primary care
- Preventive care
- Specialty care on referral
- Emergent and urgent care
- Ancillary services
- Enabling services
- Mental health services
- Dental

Health Care Safety Net

Funding Sources

- Federal grants
- OHP payments (sometimes enhanced)
- Medicare payments (sometimes enhanced)
- Government grants/contracts
- Fund raising (foundations, individual giving, and corporate sponsors)
- Private/commercial insurance
- Patient fees

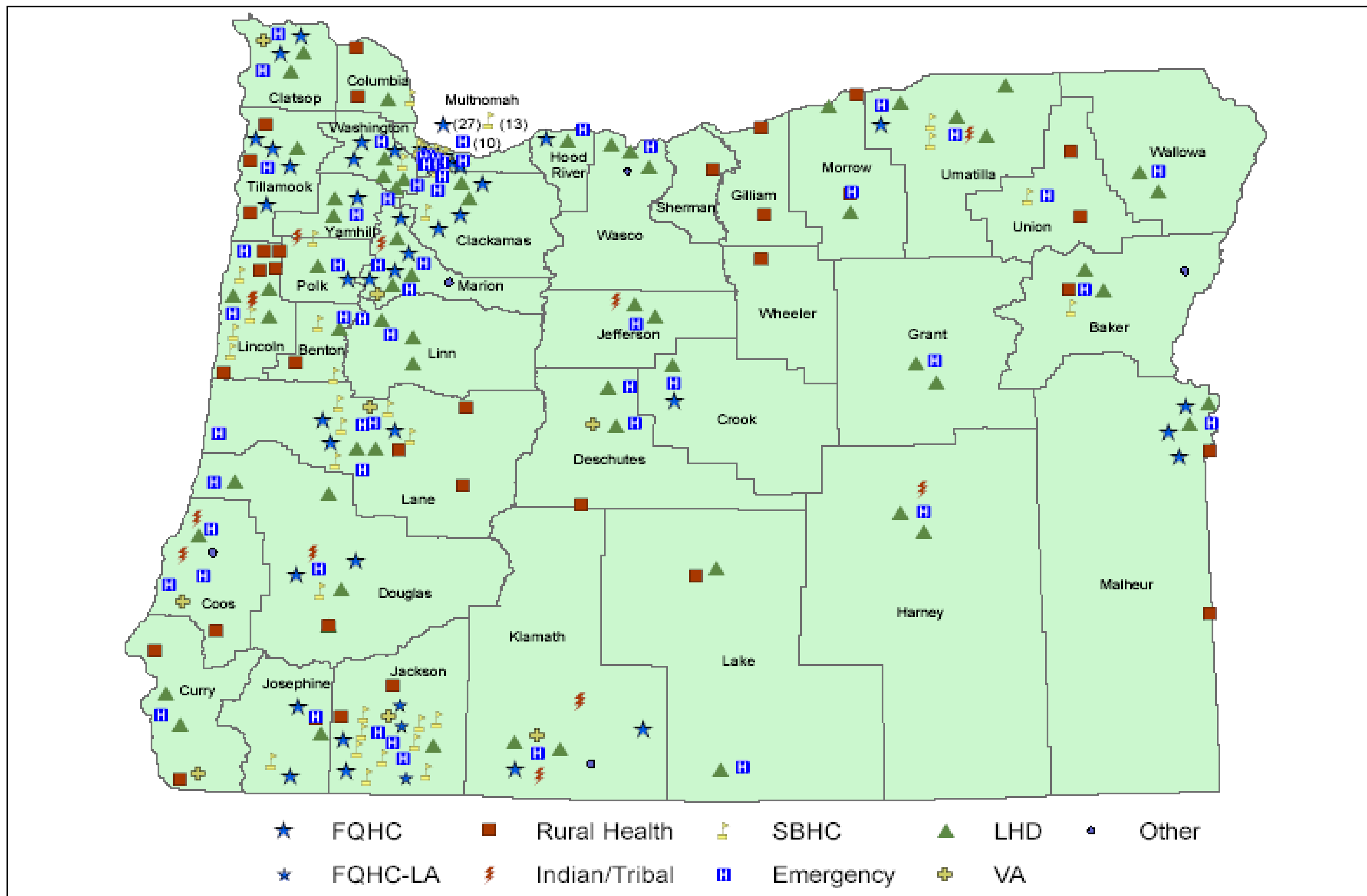
Health Care Safety Net Clinics

Types

- Federally Qualified Health Centers
- Rural Health Clinics
- School-Based Health Clinics
- Local Public Health Agencies
- Indian/Tribal Clinics
- Hospital emergency departments and clinics
- Other/Community Clinics

Oregon Safety Net Clinics 2004

(299 Sites: FQHC, FQHC-LA, RHC, SBHC, ED, Tribal, LHD, VA, Other)



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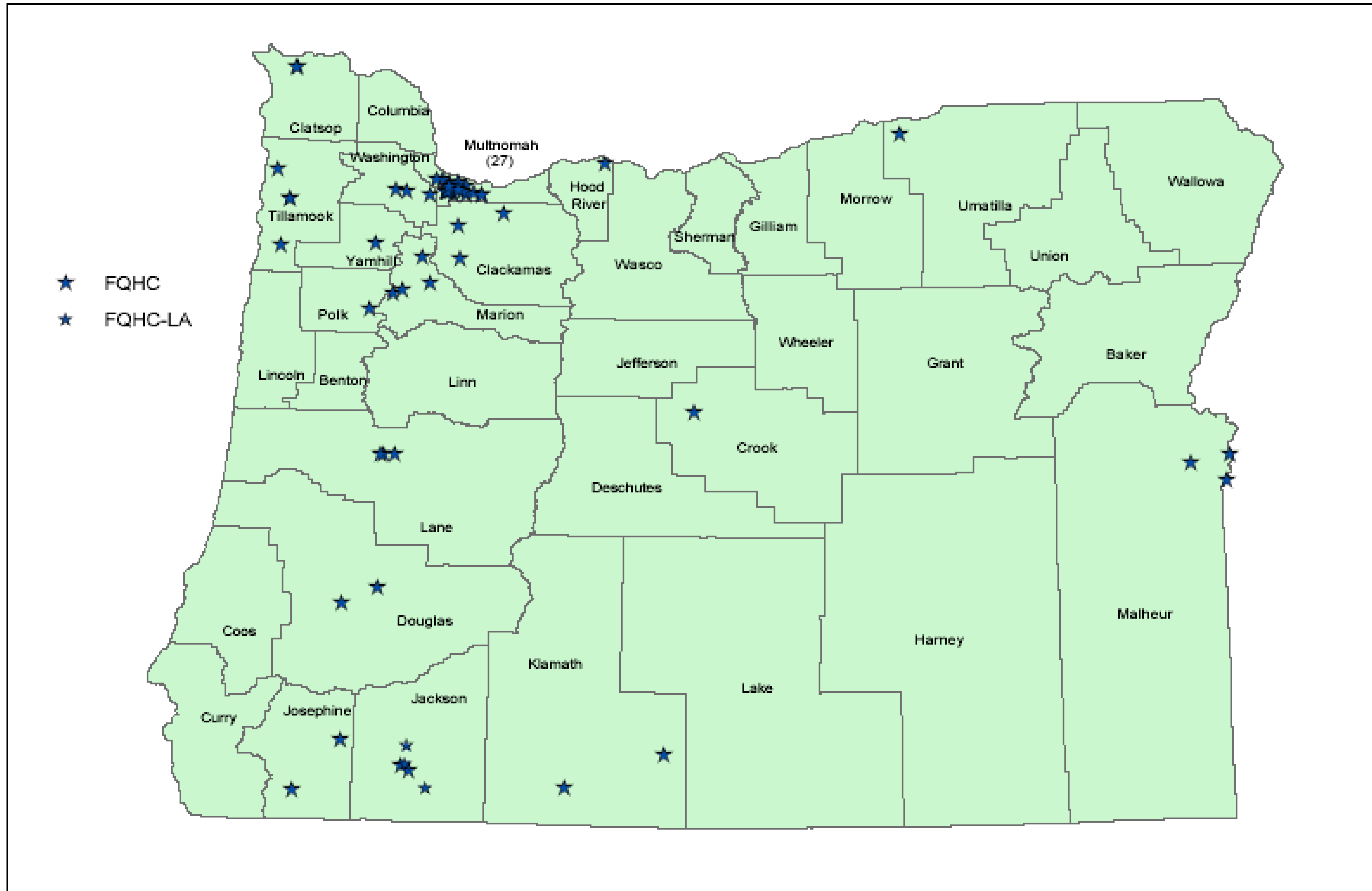
Federally Qualified Health Centers
Types

- Community Health Centers
- Migrant Health Centers
- Health Care for the Homeless Programs
- Look-Alike Clinics (no federal FQHC grants)
- Public Housing Clinics
- Health Schools, Healthy Communities

Federally Qualified Health Centers
Advantages

- Federal Tort Claims Act
- Discounted Drug Pricing Program
- Federal Grant (partial payment toward cost of care for the uninsured)
- Enhanced Medicaid and Medicare payments

2004 Oregon Federally Qualified Health Clinics (FQHC)
(15 Counties and 65 Sites)



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Rural Health Clinics
Goal

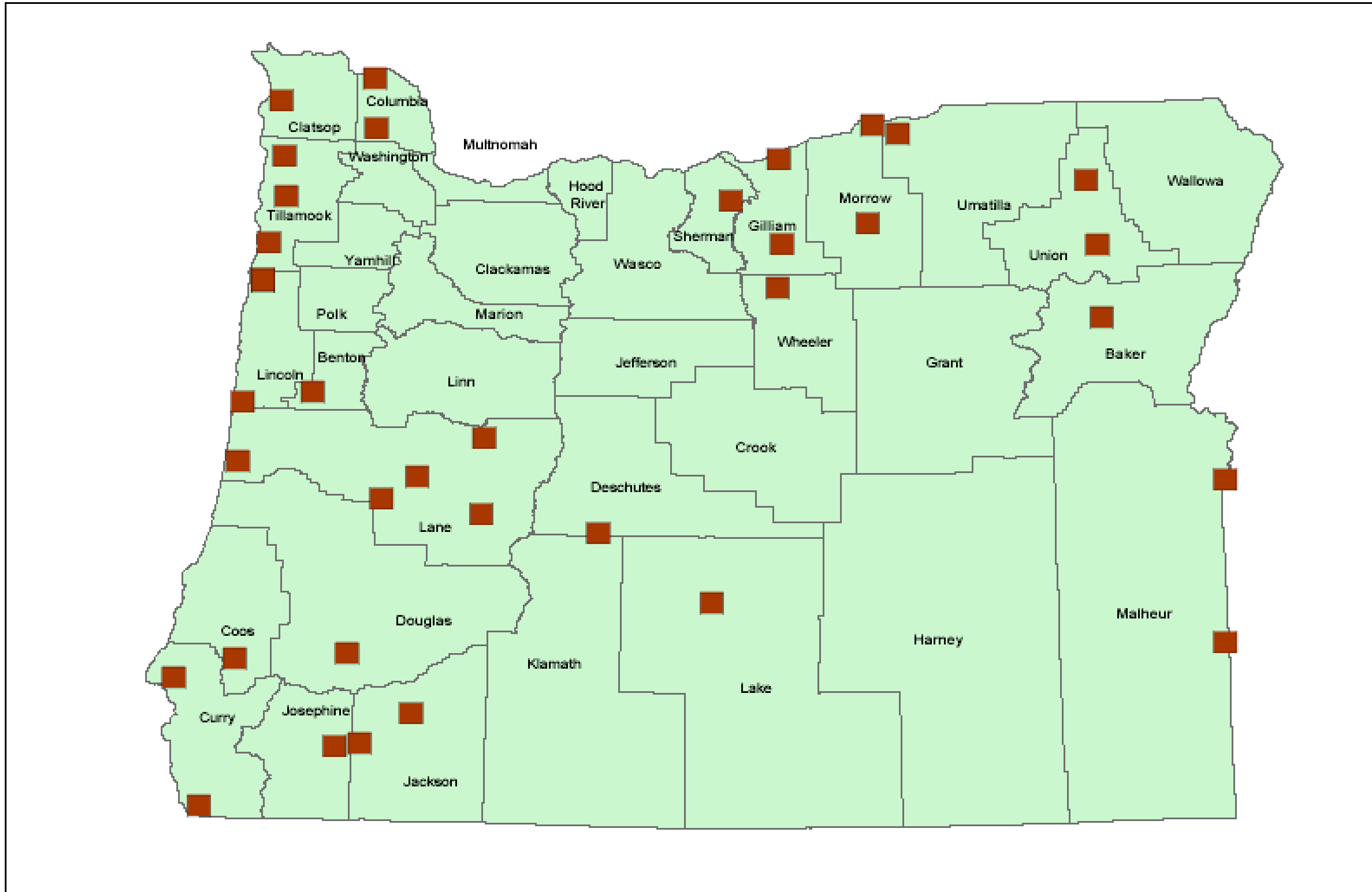
- Increase availability and access to primary care services for people in rural communities

Rural Health Clinic
Advantages

- Medicaid and Medicare enhanced reimbursement

2004 Oregon Rural Health Clinics (RHC)

(21 Counties and 38 Sites)



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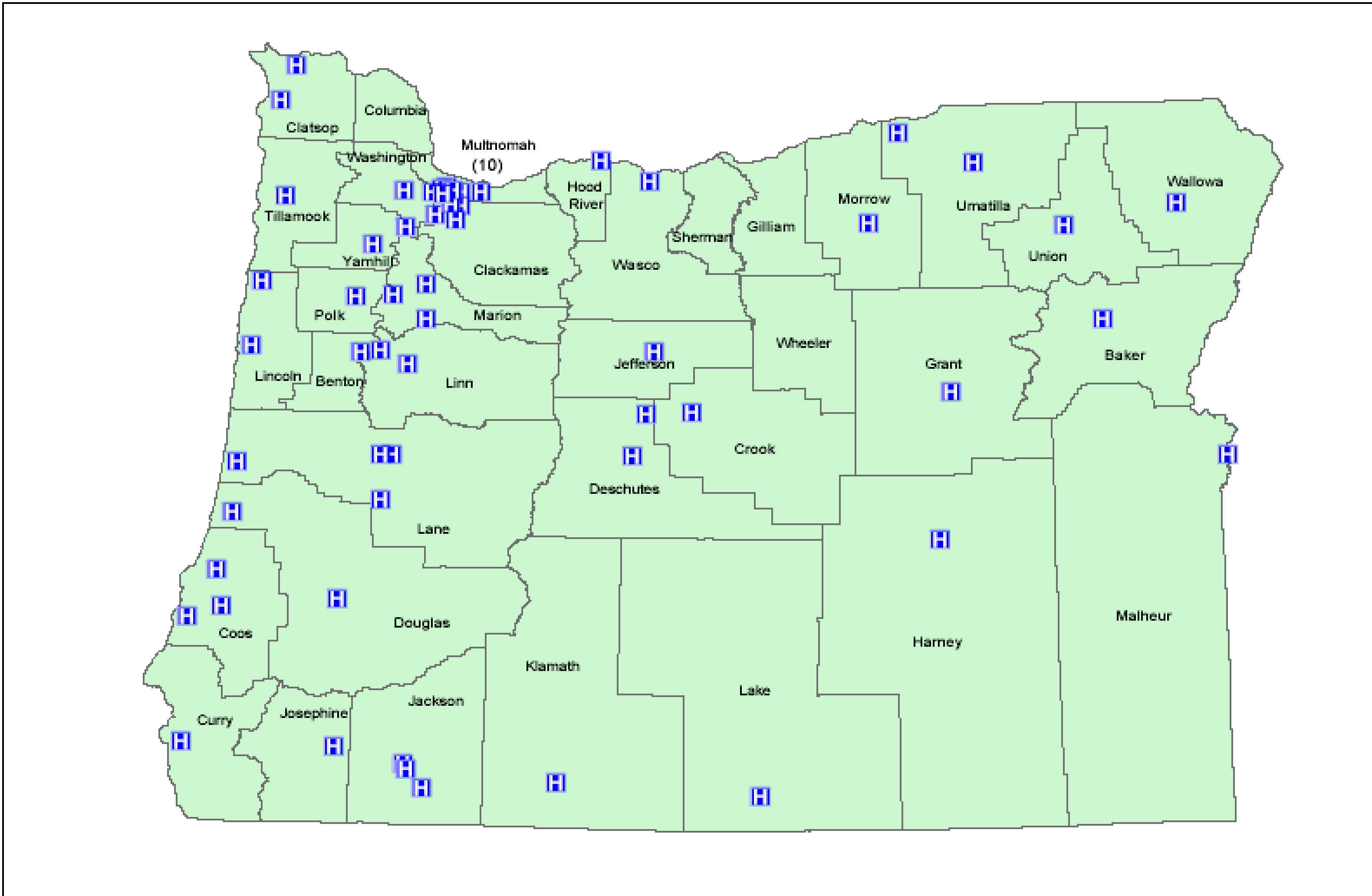
Emergency Departments

- Oregon’s hospital emergency departments and clinics are safety net providers
  - More appropriately, for patients needing emergent or urgent care, or diagnostic or clinical services on referral
  - Less appropriately, for patients seeking primary care through the emergency room

2004 Oregon Emergency Departments (ED)
(32 Counties and 59 Sites)



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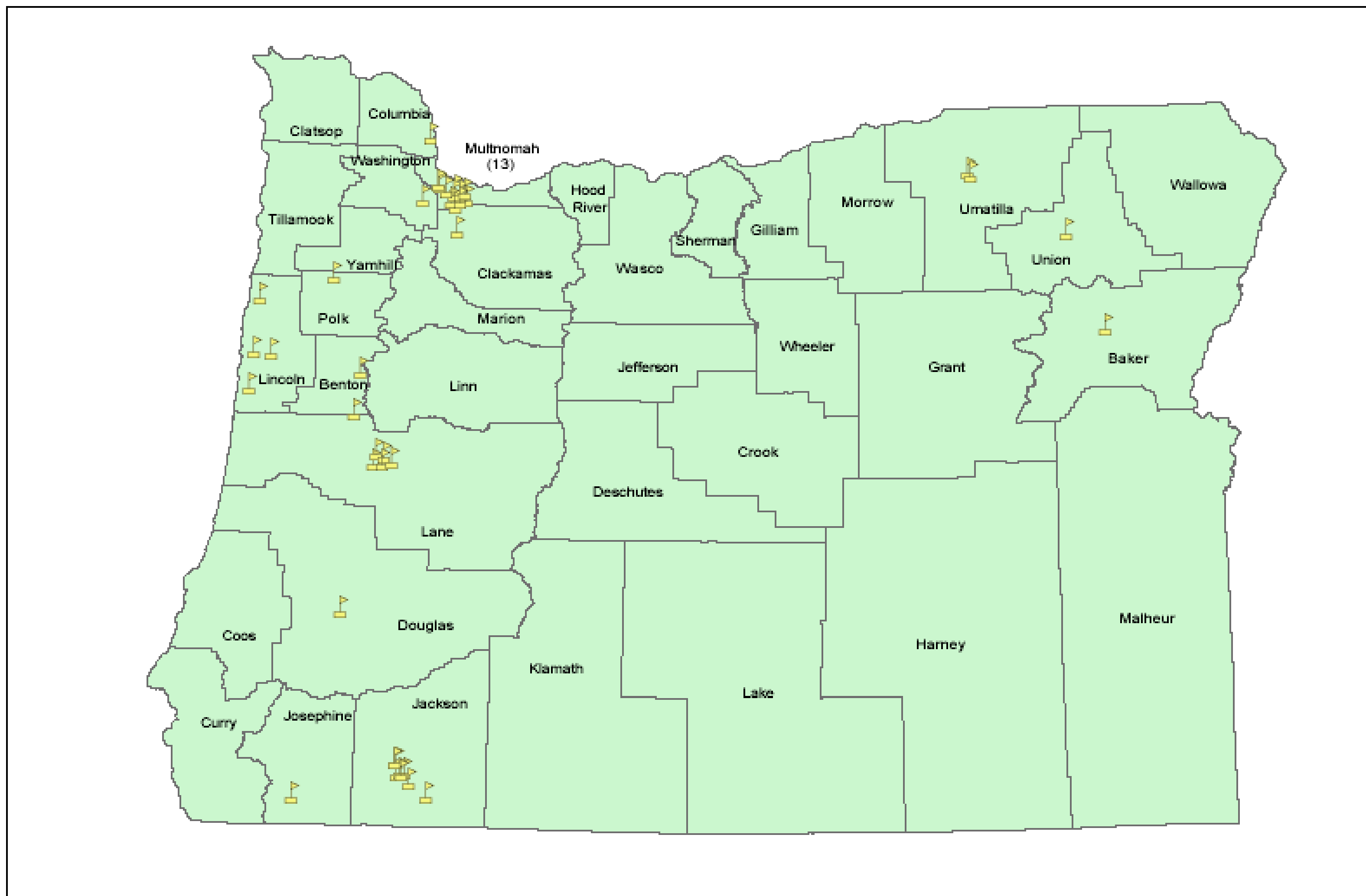
School-Based Health Centers
Goals

- Provide comprehensive physical, mental and preventive health services to school-aged youth in a school setting.
- Improve access to primary care for Oregon's school-aged youth

2004 Oregon School Based Health Clinics (SBHC)
(14 Counties and 43 Sites)



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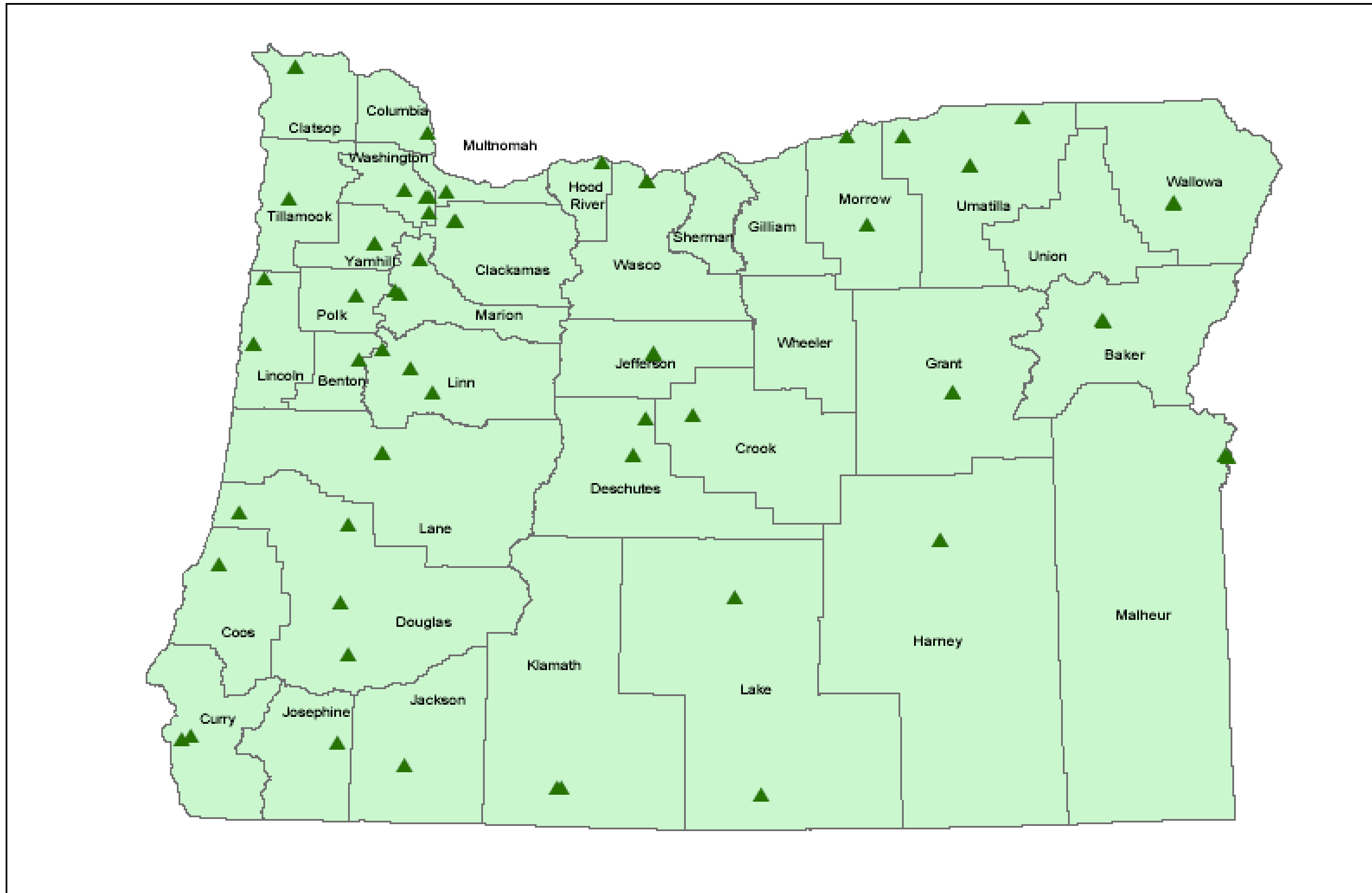
Local Public Health Authority
Services

- Acute & chronic disease prevention
- Communicable disease testing, prevention & counseling
- Lab services
- Family planning
- In some counties, full primary care services

2004 Oregon Local Health Departments (LHD)

(32 Counties and 64 Sites)



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Indian and Tribal Clinics
Goal

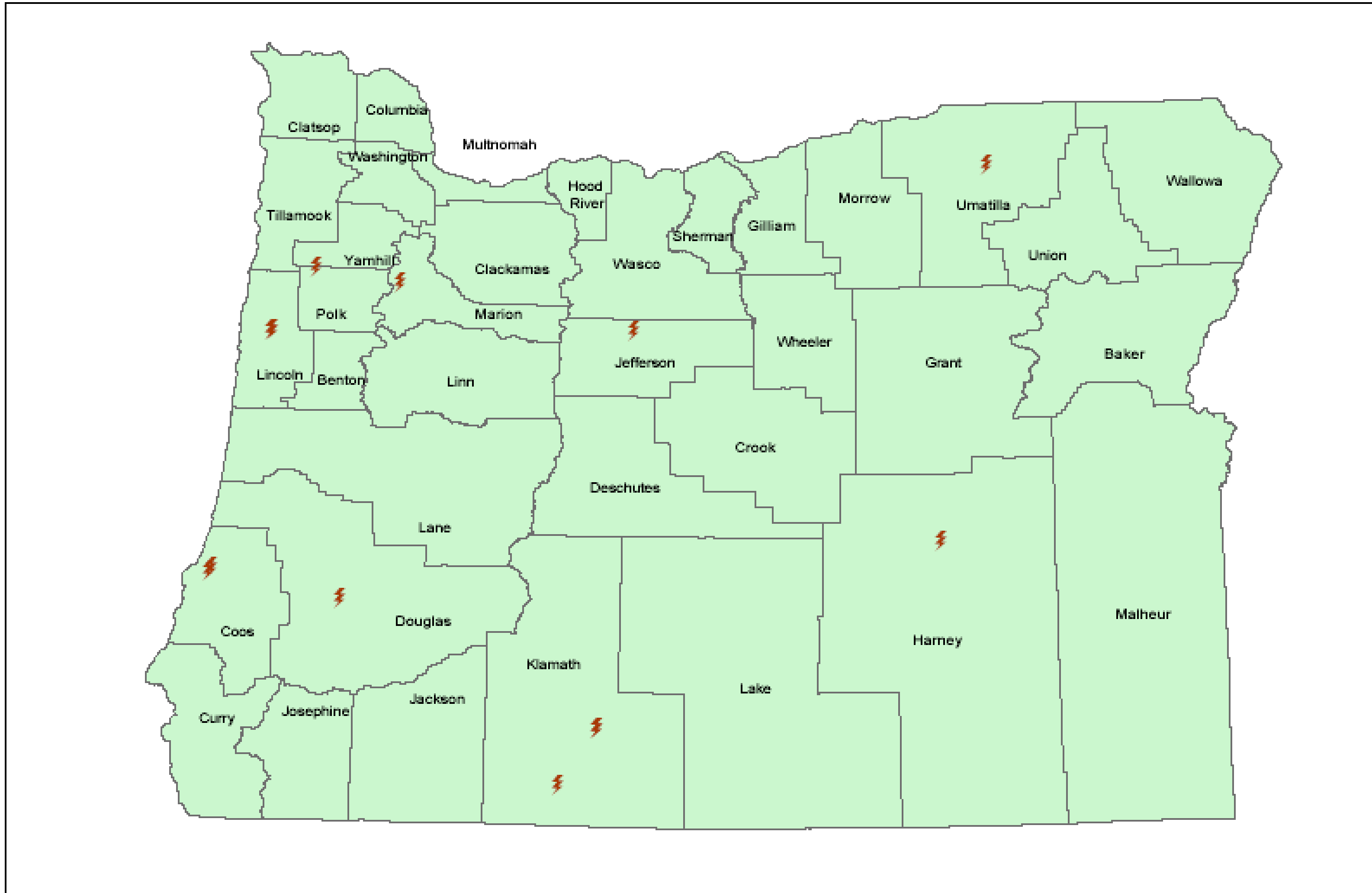
- Improve quality of life and health status of American Indian people through the delivery of culturally appropriate and holistic health services

Indian and Tribal Clinics

Typical Services

- Primary care
- Preventive services
- Dental
- Mental Health
- Substance Abuse
- Ancillary Services
- Enabling Services

2004 Oregon Indian/Tribal Health Clinics
(9 Counties and 13 Sites)



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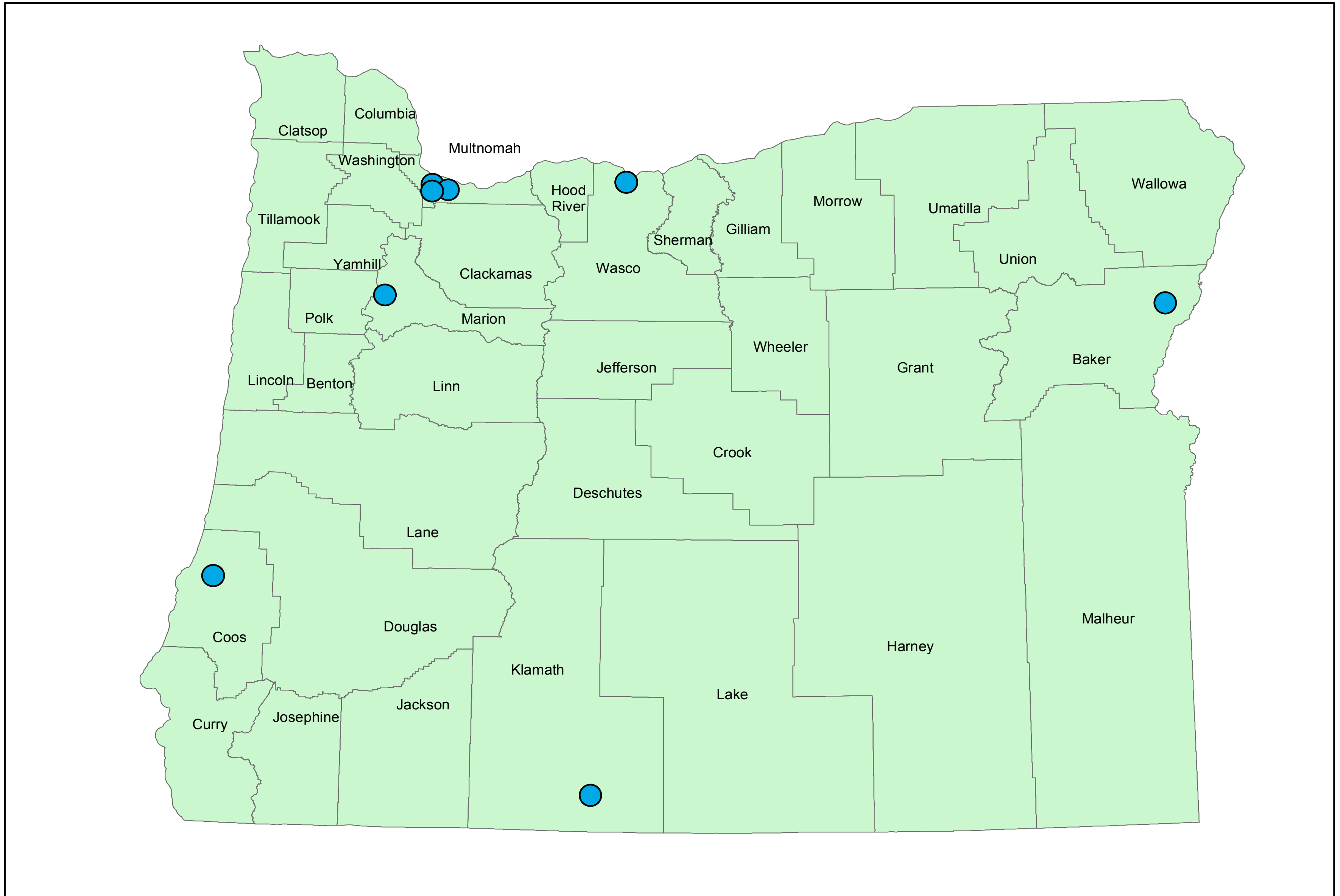
Community Clinics and Other Safety Net Providers

- Not federally defined
- Not part of a state or federal program
- Often target a particular vulnerable population, such as the homeless or the chronically mentally ill

2004 Oregon 'Other' Clinics
(6 Counties and 9 Sites)



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Workforce Programs

- National Health Service Corp
- Conrad Program
- **H**ealthcare **E**xperts for **R**ural **O**regon
- Northwest Tribal Recruitment Project
- Area Health Education Centers

Access Through Mainstream Providers

- **“Mainstream providers” can be defined as providers of health care whose typical patients are not vulnerable due to low income, culture/language differences, geography, or disabling mental health or chemical dependency problems.**
- **Many mainstream providers see OHP patients, but some have closed their practices to both Medicaid and Medicare patients**
- **Patients who become uninsured often remain with their providers, but the uninsured have difficulty finding new providers**

Mainstream Provider Types

- Independent practice physicians
- Group practices and clinics
- Ambulatory Surgery Centers
- Hospitals
- Pharmacies
- Other ancillary providers

The Delivery System, Insurance, and Access

- **Managed care typically combines insurer and provider in one organization, which allows incentives to be realigned with the goal of promoting appropriate access.**
- **Financial incentives are at work both in the prospective payment common in managed care, and in fee-for-service payment. The first can lead to under-utilization, the second to over-utilization. Both require monitoring to assure appropriate access and quality of care.**

The OHP Delivery System and Access: A Case in Point

- In the mid-’60s to mid-’80s, fee-for-service Medicaid payments below the cost of care led to rising costs and inadequate access. Payment per service was low, but the mix of services provided was often inappropriate and expensive. Medicaid patients got too much of some kinds of care, not enough of other kinds of care.

The OHP Delivery System and Access: A Case in Point

continued

- Managed care came to Oregon Medicaid in the mid-'80s, as a way to re-shape the mix of services provided and to improve access. Serious problems with access to primary care and maternity care were largely resolved in areas where managed care was introduced.

The OHP Delivery System and Access: A Case in Point

continued

- **With the implementation of the OHP in 1994, fully capitated health plans were introduced, with capitation payments based on the costs of care.**
- **Initial experience was positive: commercial health plans participated and expanded managed care into nearly all parts of Oregon. Subsequent experience was less positive, and commercial health plans left the OHP entirely or retrenched into the Willamette Valley service areas.**

The OHP Delivery System and Access: A Case in Point

continued

- As the commercial plans left many areas of the state, community-based plans were formed to fill the managed care gap. These community-based plans were designed specifically to serve the OHP populations.
- Three examples or these community-based health plans are: CareOregon, Inter-Community Health Plan, and Central Oregon Independent Health Systems.

Studies Completed, Findings Presented, Questions Posed

- A number of studies have been done on access in Oregon, in the OHP and in general. These include:

1. "Health Care Delivery Systems in Oregon" - 2000
2. "Small Market Study" - 2001
3. "Access to Health Care in Oregon" - 2002

Findings of Access Studies

- There appear to be three major determinants of success for OHP delivery systems
  1. Mission to serve all members of a community
  2. Governance and control at the community level
  3. Equitable distribution of resources based on collaborative partnerships

Findings of Access Studies
continued

- Other elements of OHP delivery system success include
  - **Diverse partners, including physicians, hospitals, and safety net clinics**
  - **Effective physician and hospital leadership**
  - **Alignment of incentives so that partners win or lose together, and adjustments are made as necessary**
  - **Timely distribution of accurate information about physician, clinic, and hospital performance**

Findings of Access Studies

continued

- Additional elements of OHP delivery system success
  - **Explicit arrangements for balancing and meeting the needs of all populations, including Medicaid, Medicare, privately insured, and the uninsured**
  - **Recognizing and accounting for uncompensated care throughout the delivery system**
  - **Constructive connection between the delivery system and the economic development of the community**

Findings of Access Studies
continued

- In 2001, the uninsurance rate was 12.5% statewide, and varied from 7.2% in Columbia Co. to 17% in Malheur Co.
- In 2003, the uninsurance rate was 14% statewide, and varied from 10.8% in Clackamas Co. to 19% in Wasco Co.

Findings of Access Studies
continued

- In 2001, the population under 200% FPL varied by county from a low of 16% in Washington Co. to a high of 59% in Malheur Co. Eleven counties had from 44% to 59% of their populations below 200% FPL.

Questions Posed

- When does Medicaid enrollment not assure access to appropriate care? Why?
- Is there a role for other models, in addition to fully capitated health plans?
- What is the impact of the OHP on access to care for those outside the OHP (Medicare, privately insured, and uninsured)?
- What is the impact of Medicare, private insurance, and the uninsured on access to care for those on the OHP?

Questions Posed

- **What populations are not a good fit with the insurance model. Why not? What alternatives are better models for assuring access to these populations?**
- **How can the safety net be expanded to meet growing need when the economy is bad and revenues are down?**
- **To what extent is employer-sponsored insurance eroding, and with what effect? What does this mean to access, and what (if anything) should be done about it?**

Questions Posed

- How have payment changes in Medicare and private insurance affected the OHP and access for the uninsured?
- How have payment changes in the OHP affected Medicare and private insurance and access for the uninsured?

Strategies and Recommendations

- The State should increase the flexibility of models available for OHP contracting health plans.
- The State should prioritize the issues affecting access to care, and develop responses, within the OHP and other State funded programs, that will improve access throughout the system.

Strategies and Recommendations

- The State should support through policy and local action the growth of community-based governance, resource allocation, and delivery system models.
- The State should work with stakeholder groups to identify and address health disparities in racial and ethnic communities.

Strategies and Cost Sharing

- The state should support more efficient and effective use of safety net providers to meet the needs of uninsured Oregonians and Medicaid recipients.
- Employer-sponsored insurance should be bolstered by addressing affordability for both employers and employees. This may involve both subsidies, and changes in covered benefits and cost-sharing.