

OREGON HEALTH FUND BOARD – Federal Laws Committee

April 22, 2008
1:00 pm – 5:00 pm (Digitally Recorded)

CCC – Wilsonville Training Center Room 112
Wilsonville, Oregon

MEMBERS PRESENT: Frank Baumeister, M.D., Chair
Ellen Gradison, Vice Chair
Chris Bouneff
Michael Huntington, M.D.
Mallen Kear, R.N.
Cheryle Kennedy
Sharon Morris
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: Larry Mullins
Julie James
Mike Bonetto

STAFF PRESENT: Susan Otter, Policy Analyst
Barney Speight, Executive Director, OHFB
Judy Morrow, Assistant

STAFF EXCUSED: Erin Fair, University of Oregon Law Student, OHFB Intern

ISSUES HEARD:

- Call to Order
- Approval of Agenda and April 8 Meeting Minutes
- Committee Discussion
- Provider workforce/Training of Health Professionals Panel
- Indian Health Service Tribal and Urban Programs Panel

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There was a quorum.

Chair Baumeister II. Approval of Agenda and April 8 Meeting Minutes (See Exhibit Materials 2)

Motion to approve the minutes for April 8 was seconded. **Motion passed unanimously.**

Chair Baumeister III. Committee Discussion (See Exhibit Materials 3a,b)

ERISA: Initial Draft Findings/Recommendations (exhibit materials 3a)

- Recommendation 1 - It was noted that a bill is being introduced in the U.S. House creating a safe harbor. Staff will locate this bill.
- Recommendation 2 – Discussion on the use of the word “amend,” recognizing that, since its inception in 1974, ERISA has never been revised.

- It was related that there is an opinion that the states already have some authority to collect information as long as it doesn't reach a state of burdensomeness.
- Discussion on seeking an ERISA waiver similar to Hawaii's. ERISA waiver possibility is believed to be very low.
- Broad based tax (payroll) of 5% that is being considered by the Finance Committee and ERISA implications were related by Barney Speight. The plan includes offsets for employers providing coverage (Pay-or-play).
- Policy neutrality is needed and state cannot mandate what type of coverage is offered. Amount of employer contribution in Massachusetts is discussed.
- Presentation by Dr. Pat Butler to the Committee on 03/25/08 regarding ERISA is referenced.
- Staff noted that there is background and supportive text to be added to the recommendation relating a study by the National Association of Insurance Commissioner's (NAIC) in which 2/3 of the states said that ERISA was a barrier to health reform efforts. Four recommendations, similar to this Committees', from the NAIC report are:
 - 1) Amend ERISA to clarify that states may require self-insured plans to submit data;
 - 2) Amend ERISA to clarify that pay-or-play assessments are not pre-empted by federal law;
 - 3) Grant the Secretary of Labor the authority to grant waivers from ERISA for comprehensive health reform proposals; and
 - 4) Create a federal grant program to provide grants to states pursuing new and innovative reform ideas.
- Suggestion to incorporate NAIC report recommendations. Staff will look at the suitability of NAIC recommendation 3, which grants the Secretary of Labor ERISA grant waiver authority, for consideration by this committee.
- General agreement that Committee is comfortable with proposed recommendations.

Federal Tax Code: Initial Draft Findings/Recommendations (exhibit materials 3a)

- Discussion that, under an individual mandate, there should be some equitable federal tax treatment for those in the individual market. State can offer credit, but most relief would come from federal tax benefits.
- Suggestion that Committee recommendations should be cognizant of other discussions at federal level of changing current tax credit for health insurance and that Committee recommendations should not counter these changes, but run parallel.
 - Caveat to legislature connecting federal tax with Oregon tax
- General agreement that Committee is comfortable with proposed recommendations.

HIPAA: INITIAL DRAFT FINDINGS/RECOMMENDATIONS (See Exhibit Material 3b)

- Discussion that HIPAA is not a legal barrier but may be an operational barrier due to restrictive interpretations by various entities. Suggestion to add a recommendation for educational component.
 - Suggestion for greater specificity in finding.

EMTALA: INITIAL DRAFT FINDINGS/RECOMMENDATIONS (See Exhibit Material 3b)

- Conflict between EMTALA and Oregon law in relation to mental health treatment from testimony by EMTALA panel on 04/08/08 discussed.
 - No EMTALA recommendation regarding federal policy.
 - Suggestion to include Committee's concern that there exists a weakness in State mental health policy that conflicts with EMTALA.
- Discussion regarding emergency department (ED) testimony from 04/08/08 regarding ED use for primary care during "down times," the lack of facilities for mental health and that use of ED service in these areas reflects a broken system.
- Preventable ED use discussed.

Chair Baumeister IV. Provider Workforce/Training of Health Professionals Panel (see Exhibit Materials 4a-g)

Jo Isgrigg, Ph.D., Executive Director, Oregon Healthcare Workforce Institute (OHWI), gave a presentation on "The Federal Government's Role in Healthcare Workforce Development and Distribution." **(See PowerPoint presentation 1).**

- Gave an overview of "Oregon's Provider Picture."
- Provided statistics on Oregon's healthcare workforce, including physicians, physician assistants, dentists, dental hygienists, nurses, and advanced practice nurses.
- Projected trends modeled by the Oregon Employment Department (OED) explained.
- Federal funding budget through the Health Resources and Services Administration (HRSA), which awards scholarships and provides loans, is provided. **(See Exhibit Materials 4b).**
 - HRSA also provides funding for institutions and states through grants, including programs that target minority populations.
 - Noted several programs that are proposed to be cut by the administration.
- Loan repayment programs discussed as a recruiting tool for areas with health professional shortages.
- International Medical Graduates (IMG) through U.S. Immigration policies is discussed.
- The need to collect data to reflect an accurate picture of the existing workforce is related.
 - Related that State Senator Morse of the Subcommittee on Health Care Reform has asked the OHWI to work with licensing boards to gather information. The Oregon Board of Nursing and North Carolina has been a model of workforce data collection starting in the 1970s.

Mark Richardson, M.D., M.Sc.B., M.B.A., Dean of OHSU School of Medicine (PowerPoint presentation 2)

- Presentation focused on physician shortages.
- Massachusetts increase in number of individuals covered without an increase in providers related.
- Addressed reasons for Oregon's declining numbers of physicians including:
 - Aging workforce with half 50+ years old.
 - High malpractice insurance costs.
 - Lower Medicare reimbursement rates.

- Federally capped residency training opportunities.
- Unlike national trends, 50% of OHSU grads have chosen primary care.
- Federal cap of post-MD training positions noted.
- Oregon Medicine (ORMED) Collaborative is described including regional partnering. Funding was not continued by the last legislature but it is hoped that it will be funded at the next legislature.
- ORMED three step proposal is presented. (See slide 14).
- Statistical data on applicants, GME trainees, and percentages of graduates that stay in Oregon is related.
- Federal inequity noted in number of residents allowed under GME cap in western states when compared to U.S. in whole.
- Question asked whether women graduates end up less productive when in workforce than men. Dr. Richardson noted that newly graduated women have similar workforce productivity goals as their male counterparts.
- Strategies, including loan forgiveness programs, discussed.
- Balanced Budget Act of 1996 capped GME slots for all existing programs, but new training programs are not capped.
- Discrepancies of roles of physician's assistants and nurse practitioners from state to state are discussed.
- When asked to explain OHSU's high rate of graduates choosing primary care, the school's robust family practice program was noted, but Dr. Richardson added that the careful selection of applicants is another factor.
- Of OHSU's 270 post graduate spots, how many of those residency slots are primary care? Dr. Richardson estimated it was about 40%. If you include OB/GYN, pediatrics, internal medicine and family medicine, then it is a little better than 50%.
- In regards to this committee, are there specific federal laws that need addressing or is it mostly money? Dr. Richardson stated laws regarding GME cap and Medicare payment issue, including the reimbursement of nurse practitioners vs. physicians.
- IMG requirements, ethical considerations of training in the U.S. vs. other countries and data on returning to practice in the U.S. are discussed.

Chair Baumeister V.

Indian Health Service Tribal and Urban Programs Panel

Jim Roberts, Health Policy Analyst for the Northwest Portland Area Indian Health Board and Geoffrey Strommer, Attorney, Hobbs, Straus, Dean and Walker LLC introduced themselves, provided background information and gave a presentation on the "Indian Health System." **(See PowerPoint presentation 3 and Exhibit Materials 5a,b,c,d)**

- Nine federally recognized Oregon Tribes identified.
- Oregon's Urban Indian Program "Native American Rehabilitation Association (NARA)" located in Portland provides services to approximately 7,000 American Indian/Alaskan Native (AI/AN) individuals.
- Examples of "non-beneficiaries" (legal term relating to non-Indians that are eligible for services due to special circumstances) are given.
- Importance of Indian policy to Federal Laws Committee and OHFB:
 - Impact on Indian policy possibly due to changes to federal laws.
 - Importance of Medicare, Medicaid and SCHIP programs related.

- Oregon policies could be precedent setting and impact Tribes outside of Oregon.
- Federal Trust Responsibility and relationship between U.S. Federal government and Indian Tribes explained.
 - History including the Treaty Clause and Supremacy Clause of the Constitution that gives Congress supremacy over Indian affairs, Federal Trust Responsibility defined through interpretation by the courts (including health care), no inherent rights of States to deal on political level with Tribes, and political relationship between two sovereigns is presented.
 - Historical information on the termination of special relationship with Tribes in the 1940's and 50's described.
 - Self-Determination Era in the 1960's and 70's by President Nixon led to a shift in federal policy that gave Tribes authority over operation of programs. Self-Determination Act of 1975 described. Choice between self-governance and Title I contracts of Tribes related.
 - Presenters will provide staff with a list of Oregon Tribes of self-governance vs. Title I.
 - Indian Health Care Improvement Act (1976) described as key Indian health federal law. This act with Self-Determination Act provided framework for the health care delivery system operating at Tribal level.
 - Medicare, Medicaid, SCHIP, and Medicare Modernization Act related followed by background on IHS.
 - Research indicates that when Tribes assume programs from feds, quality improves while those that remained in the direct service had decreased services and closed down facilities. Attests to the efficiency of Tribal governments in managing health care.
 - Northwest is the originator of many changes in policy.
 - IHS provides outpatient, ambulatory, primary care; inpatient care hospitals; medical specialties, traditional healing; dental and vision care, behavioral health and specialty care services.
 - Portland area does not have Tribal inpatient hospitals. More efficient to purchase care. Tribes in the Portland area are researching establishing an inpatient medical center.
 - Question: Is the model being considered similar to the Anchorage facility? Yes. The Alaskan Native Medical Center, has regional health center that feeds into a tertiary care.
- Data demonstrating significant AI/AN health disparities are presented.
- Per capita funding inequities presented in graph. Funding is number one issue.
- Guiding principles for Medicaid reform discussed.
 - There is no cost to state for programs through Medicaid and SCHIP due to 100% federal match.
 - No cost sharing requirements.
 - Benefit design and loss of benefits as a result of the implementation of the OHP Plus plan, even though there is no cost to state, discussed. Money lost in matching funding.
 - Developing recommendations that will not negatively affect Indian health care.
- Question: Does a Tribal member in Oregon, eligible for Medicaid, have the choice of managed care vs. fee-for-service? Yes. If they do not choose within a certain time period they will automatically be enrolled in a managed care plan.

- Question: Since most Oregon Tribes have Tribal operated health services, do they participate in Medicaid managed care plans or not? Committee Member and Council Chairwoman of the Confederated Tribes of Grand Ronde, Cheryle Kennedy, responded that they do now, but it was difficult process and were disallowed in the beginning.
- Rights to culturally competent care and traditional medicine are stated.
- The unique circumstances related to the Indian Health System (see slide 31), including treatment to non-Indians, are highlighted. It was related that many are community health centers with a 330 designation under HRSA and must provide services to non-Indians.
- Refers to pg. 71 of document by Carol Barbero, Esq. (**See Exhibit Materials 5b**) outlining circumstances.
- Questions and discussion on funding for Tribal members served including Contract Health Services (CHS) program, formula for funding, rationing of care and priorities one and two explained with CHS chronic underfunding stated.
 - To deal with underfunding, some Tribes cost shift money from line items (e.g. mental health, dental health) into CHS program to provide more care through that program but reduces services in the other categories.
- Only Tribes have rights under Indian Self-Determination and Education Assistance Act (ISDEAA), not Urban Indian programs.
- Development of mid-level practitioners, initiated in Alaska, discussed.
 - Dental health aide designed from New Zealand model.

Discussions and Questions

- Are physicians supplied to the IHS through the federal government for a period of time, such as in the military? The IHS recruits through regular process and through the Commission Corp.
- Do you have any relationship to try and arrange for AI/AN individuals who are interested medical school, such as in the Dakotas, to attend and return to serve the Tribal population? Related information regarding the Indian Health Care Improvement Act, Title II, provision for national scholarship funding. There are no slotted positions.
- The role of the Federal Laws Committee in relation to the special role of the Indian Health Services is summarized as an awareness issue to alert other committees of the special relationship with the federal government. This is important to ensure that Committee/Board recommendations do not harm existing programs that have been gained after long struggles. The adverse effects on Tribal health care with changes to the Oregon Health Plan (OHP) were identified. It was noted that some problems have been addressed in SB 878, which would afford Indians on the Standard plan to receive the same benefits as those in the Plus plan. SB 878 passed in 2002 but still has not yet been approved by CMS for implementation.
- The overlooking of the public health role of the IHS by State public health has added to health disparities.
- Clarification that health disparities data presented is national. It was related that Oregon data is similar.
- IHS CHS funding formula of 70% population/30% health status markers within capitated limit is explained.
- There is an opportunity to address the health disparities of the Tribal populations through a benefit design as the federal government will reimburse these health care expenses 100%. However, the

relationship between the Federal government and Indian Tribes must be weighed when considering all recommendations as they have the potential to inadvertently, negatively affect Indian health care.

- Question on services provided to an AI/AN individual who is covered through his employer. IHS will provide care but reimbursement eligibility depends on provider. Barney Speight related Washington State Law that requires IHS providers to be treated as participating providers in any commercial health plan that is serving a Tribal member covered by that plan. This is identified as a possible recommendation for the Board to consider.
- Jim Roberts thanked the Committee and Barney Speight for recognizing the need to include Tribal representation in the committees.
- Differences between other regions illustrated. For example, Alaska and other regions have hospitals and receive IHS funds while Northwest and Great Lakes Tribes do not have hospitals and rely only on CHS funds for some areas of care.
- Summary of eligible reimbursements outlined:
 - Portion of Tribal membership on Medicare if served by IHS does not receive reimbursement, Tribal health units were excluded. If they go outside the system, then it is paid.
 - In Oregon, Medicaid/OHP is reimbursable.
 - If insured through employer, must be an eligible provider. There is an application process to obtain eligibility. Difficulty is experienced with turnover of eligible providers.
 - If uninsured, services are paid through IHS funds.
- Estimates of distribution over the above categories with the uninsured being the greatest percentage.
- Problems include designation as a public health unit and transportation.
- Payment for visit for only one treated condition/day is related.

Chair Baumeister VII. Adjourn

The meeting was adjourned by Chair Baumeister.

Next meeting May 13, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Draft Agenda for April 22 meeting
2. Federal Law Committee minutes of 04/08/08.
3. Draft Recommendations
 - a. ERISA and Federal Tax Code Draft Recommendations
 - b. HIPAA and EMTALA Draft Recommendations
4. Provider Workforce
 - a. Oregon Health Professionals Shortage Areas (HPSAs): Primary Care Designations Map, Jan. 2008
 - b. "Federal Programs to Increase the Supply of Workers in Primary Health Care," Congressional Research Service, April 2008.
 - c. "PRIMARY CARE PROFESSIONALS: Recent Supply Trends, Projections, and Valuation Services," GAO Report # GAO—08-472T, Feb. 2008
 - d. DHS letter to CMS regarding changes in Graduate Medical Education program
 - e. Excerpt from "Oregon Health Care Workforce Needs Assessment 2006," Oregon Employment Department
 - f. Excerpts from "Student Completing Healthcare Workforce Studies in Oregon: Supply Trend Analysis, May 2007," Oregon Healthcare Workforce Institute
 - g. "Partnerships and Investments in Oregon's Healthcare Workforce: Private and Federal Government Contributions Jan. 2008-March 2007, Oregon Healthcare Workforce Institute
5. Indian Health Service Tribal and Urban Programs
 - a. Northwest Portland Indian Health Board Letter to OHFB, January 31, 2008.

- b. "Legal Basis for Special CMS Provisions for American Indians and Alaskan Natives," Carol Barbero, Esq., Hobbs, Straus, Dean and Walker, LLP.
 - c. "Health Disparities Challenge Public Health among Native Americans," Jim Roberts and Joshua T. Jones, Northwest Public Health, Fall/Winter 2004.
 - d. "HIPAA and Patient Privacy: Tribal Policies as Added means for addressing Indian Health Disparities," S. K. Roels, Esq., American Indian Law Review, Vol. 31 No 1, 2007.
6. Summary of Proposed HB HR 3162 "Champ Act of 2007", section 304, proposing 5% increase in Medicare payments to efficient physicians.
 7. Research and follow-up on previous topics:
 - a. Summary of April 7 staff meeting with DHS Office of Addictions and Mental Health
 - b. 2008 Kinsman Ethics Conference Summary Paper
 8. Copies and follow-up documents to April 8 meeting:
 - a. "Summary of the Access to Emergency Medical Services Act of 2007," American College of Emergency Physicians
 - b. "Vast difference in spending patterns for chronically ill." Kevin Freking, AP Wire, April 8.
 - c. "Medicare Finds How Hard it is to Save Money," R. Abelson, New York Times, 04/07/08.
 - d. "Oregon ERs lack specialists," J. Rojas-Burke, The Oregonian, 04/09/08.
 9. Delivery Systems Committee Progress Report

PRESENTATIONS

1. "The Federal Government's Role in Health Care Workforce Development and Distribution" by Jo Isgrigg, PhD.
2. "Healthcare Reform, Provider Education and a federal regulatory quirk" by Mark Richardson, M.D., MPH.
3. "The Indian Health System" by Jim Roberts and Geoffrey Strommer.