Oregon Office of Rural Health

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Testimony re: HB 3396
Joint Committee on Ways and Means Subcommittee on Human Services
June 23, 2015
Scott Ekblad, Director, Oregon Office of Rural Health

Co-Chair Nathanson, Co-Chair Bates, Members of the Committee:

There has been quite a bit of discussion during the past few Legislative sessions regarding the state's various healthcare workforce incentive programs. A work group was formed during the 2013-15 interim to compare their effectiveness and to see if they could be better aligned. At the same time, the Oregon Healthcare Workforce Committee was tasked by the Oregon Health Policy Board to do essentially the same thing. The consensus of both groups was that we cannot make informed decisions without better data and, more importantly, ongoing analysis and evaluation of these programs to determine whether they need to be changed and how.

HB 3396 and the proposed -13 amendments would make several broad policy changes without the benefit of better data and analysis. Please allow me to share some of my observations with you.

- To extend the Rural Practitioner Tax Credit to urban practitioners effectively nullifies the original intent of the program. The tax credit served as a carrot – an extra incentive – to choose to practice in a rural community. If that carrot is available in both urban and rural it is no longer a carrot.
- The proposed changes to tax credit eligibility could increase the number of potentially eligible recipients from the current 2,100 to 7,280. That is an increase of more than 5,000, with a potential revenue impact of $50 million/biennium. Admittedly, since the bill instructs the Oregon Office of Rural Health to determine what constitutes "medically underserved," we cannot precisely predict the number of practitioners who would become eligible at this time. The above estimate assumes that we use the commonly accepted federal designation of "Health Professional Shortage Area" (HPSA). It also assumes that everyone who is eligible would be willing to keep their practices open to a minimum level of Medicare and Medicaid clients. Let's assume that we arrive at a more restrictive definition of medical underservice, and that many of those otherwise eligible would choose not to claim the credit due to the Medicare/Medicaid requirement. A low estimate would still likely mean that the number of people claiming the credit would more than double.

- HB 3396 would eliminate the current eligibility requirements around hospital affiliation, and I fully support that change. I honestly don't know the reasoning behind the existing affiliation requirements, but assume they were due to market forces present in 1988 that do not exist today. They serve only to unnecessarily complicate the program and is perceived by applicants as pointless red tape serving no purpose other than to randomly exclude providers from the benefit.
- The state loan repayment program and the loan forgiveness program would be combined into one fund, with the ability to shift funds from one program to the other according to perceived need. The loan forgiveness program is intended solely for graduates of rural training programs who agree to fulfill their obligation by practicing in rural communities. Once the funds for the loan repayment program – which benefits both urban and rural underserved – are combined with a "rural only" program that works with an inherently smaller pool of applicants, funds will be shifted from the smaller rural program. The unintended policy consequence is that a program designed to give an advantage to rural recruitment efforts will be undermined.
- This legislation provides for a study of all incentive programs to determine their relative return on investment, upon which the Legislature can base decisions in the future. I fully support this but have serious doubts that anything of substance can be completed by February of 2016. I recommend that the timeline be extended through 2016, so that we can be prepared to make recommendations during the 2017 Legislative Session.
- All incentive programs would be eliminated in January of 2018. I understand what I assume is the reasoning behind this but, without anything in the law to assure incentives will continue in some form, these programs effectively lose their recruitment and/or retention value. A program that is "on the books" for only two years is not a powerful enticement for someone deciding whether to relocate from out of state.

It is true that the various provider incentive programs we work with today came about individually, at different times, to meet differing needs. I agree that periodic reassessment and adjustment is wise and responsible. But in order to do that we must have a system of data collection and analysis that is able to answer the questions we need to have answered, before we make drastic changes with clear policy implications. The Oregon Office of Rural Health is ready, willing and eager to join the effort to find data-driven, evidence-based consensus regarding the state's health care workforce incentive programs.

Thank you for this opportunity to speak with you today. I am happy to answer any questions you might have.