HEALTH POLICY AND ANALYTICS DIVISION

Kate Brown, Governor

Oregon Health Authority

421 SW Oak St.
Portland, OR 97204

Testimony Narrative
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HB 3261: Relating to health care provider incentives; prescribing an effective date

Presenter: Marc Overbeck, Director of the Office of Primary Care, Health Policy and Analytics Division

Good afternoon, Chair Greenlick and Members of the Committee, I am Marc Overbeck, Primary Care Office Director, with the Health Policy and Analytics Division of the Oregon Health Authority.

While the agency is officially neutral on this bill, HB 3261 provides direction and guidance on the next steps in reforming Oregon's health care provider incentive programs. For some time, legislators have expressed a keen interest in Oregon's state funded incentive programs and other efforts to ensure a robust and well trained health care workforce throughout the state. These efforts began with the establishment of the Healthcare Workforce Committee under the direction of the Oregon Health Policy Board and supported by the then newly formed Oregon Health Authority (OHA) in 2009. The creation of the Health Care Workforce Reporting Program in ORS 676.410 allowed the state to better understand where our health care providers are, what services they provide, and who they are serving. Representative Nathanson provided the next push for coordination of effort with a call for a strategic plan for workforce recruitment in Oregon -- passed as HB 2366 in 2011. A plan was developed and brought to the Oregon Health Policy Board and legislators in early 2013.

Since then, additional incentive programs have been adopted by the Legislature, including the Medicaid Loan Repayment Program and Scholars for a Healthy Oregon (both in 2013), and work has continued to determine what is the most effective use of state funds to support recruitment and retention of health care providers where they are most needed.

In 2014, OHA staff developed a comprehensive matrix of the 13 federal and state incentive programs to demonstrate various funding resources and criteria. This was used in a report completed by the Health Care Workforce Committee on Oregon's programs to help facilitate discussion about the variety of programs currently in place. Last year, the Oregon Health Policy Board submitted its recommendations to the Legislature on Provider Incentive Programs in Oregon, as required under HB 3396 passed in 2015.

Reforming Oregon's programs for maximum effectiveness is a process that is taking place over time, and it's on the right track. HB 3261 is intended to help keep Oregon moving forward.

OHA would like to offer its reflections and recommendations to the bill as introduced here:

- Given that the intention of this bill, as OHA understands it, is to bring provider incentive programs together for greater effectiveness, please consider expressly naming the

Primary Care Loan Forgiveness Program in ORS 442.574 as a provider incentive program in Section 1 of the bill. Please also consider dissolving the Primary Care Loan Forgiveness Fund in ORS 442.573, with the moneys remaining in the fund also being placed into the new Health Care Provider Incentive Fund. That would serve the purpose of including every program receiving an appropriation from the General Fund to be included in this bill.

- Developing a common application for programs is something that can make the programs more user-friendly. OHA has begun the process of determining requirements to complete such as task—whether it be with staff internally or through contracting out with a vendor. As part of this process, we have been identifying systems used by other states to help us determine how best to do this. The directive to OHA to maintain a website with information about each program is clear and we are also looking at models for the best way to make information easy to find and utilize, at a reasonable cost to the state.

- Regarding the oversight of the Health Care Provider Incentive Fund established in statute, effective January, 1, 2018, OHA is prepared for this role. Our work with our colleagues at the Oregon Office of Rural Health since 2014 in overseeing what has become the Medicaid Primary Care Loan Repayment Program has been a demonstration of what a strong partnership can look like between our two entities. Under this program, the first group of participants are completing their obligations this month -- 66 providers across medical, dental and behavioral health have committed to serving high percentages of Medicaid consumers in both rural and non-rural areas of the state where expansion has taken place.

- The addition of Medicare-covered individuals as a target group to benefit from the new program is a matter of policy prerogative for the Legislature to consider. The purpose of targeting providers serving Oregon Health Plan consumers in 2013 was in anticipation of our large Medicaid expansion. If HB 3261 is approved in its current form, OHA will work with the Office of Rural Health and other stakeholders, under guidance from the Oregon Health Policy Board Health Care Workforce Committee, to develop priorities for awards under this program that are consistent with legislative intent. However, if the intention of the change is to ensure that incentive programs are targeted to serve the needs of a broad group of Oregonians who may not be able to access health care, we would propose that the language be broadened to include Medicaid, Medicare, and Low-Income Uninsured. We look forward to hearing more from the Legislature on what priorities it wants to set in this area.

- Regarding the tax credits, two things stand out: 1) In the Listening Sessions held last year by the Health Care Workforce Committee, we heard from many across the state about the need for additional preceptors to help train health care providers in rural areas; and 2) the study of incentive programs conducted by the Lewin Group last year found little evidence of an impact on the attraction of providers to an area on account of the tax credit but did identify a positive effect on the retention of providers over time. One of Lewin's suggestions was to limit the number of years a provider could utilize the tax credit after locating to a rural area. Legislators have been considering the rural

medical provider tax credit for a number of years and we defer to legislators' assessments on the continued use of such credits.

- The new expectations for OHA included in the bill—the capturing of additional provider data, development of new systems for reporting information and making use of incentive programs, will take time and resources to develop. We are working with the Legislative Fiscal Office to offer our best estimate of the costs involved. One suggestion to consider is that these and any other administrative costs involved be funded by whatever appropriation or other funding mechanism is used for the award program. I note that, to date, over 88% of the allocation for the Medicaid Loan Repayment Program over the past four years has gone directly providers in the form of loan repayment. OHA itself has retained less than 2% to defray expenses related to the administration of provider contracts with another 10% directed to the Office of Rural Health for its work in marketing the program and working with clinical sites and clinicians in its execution.

Thank you for the opportunity to comment on this piece of legislation; I'm happy to answer any questions you may have.