Outstanding Design Element 2: Provider Participation Requirements & Conditions (DRAFT)

PROVIDER PARTICIPATION REQUIREMENTS & CONDITIONS OUTSTANDING DESIGN ELEMENT GOALS:

The Oregon Joint Task Force on Universal Health Care (the Task Force) seeks to develop policy recommendations to support the Single Payer in achieving the following goals:

- **Recruitment and retention.** Ensure sufficient level of provider participation to fully meet the health care needs of all Plan members, including a sufficient range of specialists and a variety of provider types.
- **Provider availability.** Establish conditions of participation to maximize provider availability for Single Payer patients.

BACKGROUND

A primary goal of the Task Force Single Payer Plan (the Plan) proposal is to secure health care for all individuals on an equitable basis, with access to a distribution of health care resources and services available throughout the state. This requires robust participation in the Single Payer system among current and future providers. The system may necessitate increasing the number of health care providers serving communities and individuals that face significant barriers in accessing health care services and reducing the maldistribution of providers in Oregon. Provider participation requirements, conditions, and incentives are required to ensure sufficient participation and availability among new and existing providers throughout the state.

The Task Force will consider its recommendations regarding substitutive and supplemental coverage in December 2021 and January 2022. Regardless of its stance on substitutive and supplemental coverage, the Employee Retirement Income Security Act of 1974 prohibits states from regulating employer benefit arrangements that mimic insurance, referred to as “self-funded plans." A key question a state-based single-payer system must therefore address is:

- Will the Single Payer allow participating providers to offer services that the Plan covers to private-pay patients, including patients paying out of pocket or covered by self-funded plans? If so, under what conditions?[1]

If participating providers are allowed to bill private-pay patients, and if private-pay rates are permitted to be higher than rates established by the Single Payer entity, providers might prioritize treating private-pay patients. This could create a two-tier system, decreasing provider availability for enrollees in the Single Payer coverage, resulting in longer wait times. Prohibiting participating providers from collecting private payment for services, specifying the number of private-pay patients participating providers are permitted to treat, or limiting the amount providers can charge private-pay patients are policies that can increase provider availability to treat patients using Single Payer coverage.

[1] Congress of the United States Congressional Budget Office. *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*. May 2019. https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

SB 770 (2019)

SB 770 (2019) requires the Task Force consider reimbursement methodologies for individual, group practice, and institutional providers. The bill directs the Task Force to include in its report the role that the Single Payer Board will play in ensuring adequate workforce recruitment, retention and development. The bill does not require recommendations on a specific range of provider types eligible for reimbursement under the Single Payer, not does it offer participation requirements and/or conditions to ensure sufficient provider participation or availability. However, the Task Force has identified the need to identify provider types and participation requirements in its recommendations.

INTERIM STATUS REPORT

The draft recommendations related to provider reimbursement can be found on pages 17-19 of the June 2021 Joint Task Force on Universal Health Care Interim Status Report. Below are key provisions that relate to the provider participation requirements and conditions discussion:

- *Reimbursement methods and rates will be regionally tailored to meet the needs of providers and the populations they serve. Regional Entities are to advise the Single Payer on methods and rates of reimbursement that are regionally appropriate.*
- *Members will be able to access their preferred provider, who will be reimbursed based on region and populations served. The Plan is to advance value-based payments and expand on the notion of "value-based payment" as historically used, to allow for community input and prioritization.*
- *The Single Payer will ensure providers with a broad range of credentials are able to participate in the Plan. Envisioned is a system where the broadest possible range of provider types are eligible for reimbursement opportunities. This includes, but is not limited to, traditional health care workers.*
- *Improve pay parity across types of individual providers within specialties to foster services that are preventive, to offer cost avoidance opportunities, and/or to increase rates that are not currently adequate for effective recruitment and retention of health care professionals.*
- *Workforce development will include identification of workforce capacity compared to Oregonians' needs and working with stakeholders to address needed funding and develop opportunities for and access to training. The Single Payer will support workforce recruitment, retention and development, prioritizing recruitment of clinicians of color.*

EXISTING PROVIDER RECRUITMENT AND RETENTION EFFORTS

To contextualize the SB 770 requirement to consider the Board's role in provider recruitment and retention, it is important to review current state efforts related to this issue. There are several ongoing recruitment and retention efforts in Oregon to address issues related to workforce supply and distribution. The Oregon Health Authority Primary Care Office (PCO) conducts multiple assessments and analyses of the health care workforce throughout the state. They currently oversee more than $19 million allocated for the 2021-23 biennium for distribution of direct incentives to both licensed and non-licensed health professionals, and for health professional students to work and remain in communities that experience health inequities. PCO works in partnership with OHSU and the Oregon Health Policy Board to administer the Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program, which provides approximately $14 million per biennium to help fund community-based initiatives to expand training of health professionals and diversify the workforce. Lastly, in the 2021 legislative

session, the Oregon Legislature dedicated $80 million of American Rescue Plan funding to support a Behavioral Health Workforce Initiative, helping to diversify the behavioral health workforce, ensure culturally responsive behavioral health services, and grow the workforce through support of clinical supervision and by moving providers-in-training through to licensure at a faster pace.

For more information regarding ongoing workforce supply and distribution efforts, see Appendix A.

USING PROVIDER CONDITIONS TO ADDRESS ERISA BARRIERS

In creating provider participation requirements, states developing single-payer plans must consider how conditions of participation can address federal ERISA preemption. Two national ERISA experts, Fuse Brown and McCuskey reviewed 66 single-payer bills proposed in state legislatures throughout the country between 2010 and 2019. These proposals include policies to capture the employer-sponsored health insurance market, which covers 49% of Americans (60% of whom are covered by self-funded plans) and is a critical component for the solvency and viability of single-payer plans.[2] Oregon mirrors the national average with 49.3% of Oregonians receiving employer-sponsored coverage in 2019.[3]

In a scan of these 66 bills, Fuse Brown and McCuskey identify three key tools to capture employer expenditures:

- **Type A – Funding Plan.** Impose a payroll tax on employers, an income tax on individuals, or both to fund the single-payer plan.
- **Type B – Provider Restriction.** Require or create incentives for all provider payments to be made through the single payer entity at single-payer rates.
- **Type C – Assignment, Subrogation, Secondary-Payer.** Allow the single-payer entity to pay for services and seek reimbursement from employer plans or other collateral sources.

In Fuse Brown and McCuskey's scan, 34 of the single-payer bills across 14 states contained provider restriction policies (Type B above). California, Florida and others use the following template language, which incorporates Type B and Type C above:

> *A participating provider shall not charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and shall not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.*
>
> *However, this section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.*

[2] Erin C. Fuse Brown & Elizabeth Y. McCuskey. *Federalism, ERISA, and State Single-Payer Health Care.* University of Pennsylvania Law Review 168 U. PA. L. REV. (2020)

[3] https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22oregon%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

DRAFT PROVIDER PARTICIPATION REQUIREMENTS & CONDITIONS RECOMMENDATION:

The Task Force recommends:

- **Recruitment and retention.** The Single Payer shall align with the state's current efforts to recruit and retain providers, and to ensure sufficient geographic and cultural distribution of providers. This includes steps and approaches to ensure recruitment, retention and development of a wide range of provider types and specialties, including behavioral health providers, traditional healthcare workers, and non-physician provider personnel, and prioritizing recruitment of clinicians of color.
- **Geographic distribution.** In accordance with the Interim Status Report, Regional Entities will advise (subject to consent of the Plan) the Single Payer on methods and rates of reimbursement that are regionally appropriate. This may include regionally specific reimbursement rates and approaches intended to address geographic and cultural need.
- **Licensure and authorization.** Any health care provider who is licensed or authorized to practice in Oregon and is otherwise in good standing is qualified to participate in the Single Payer as long as the health care provider's services are performed within the State of Oregon and the service is covered by the Single Payer plan.
- **Out-of-state providers.** The Board shall establish and maintain procedures and standards for recognizing, monitoring and reimbursing health care providers located out of Oregon for purposes of providing coverage under the Single Payer for a member who requires out-of-state health care services while they are temporarily located out of this state.
- **Defining "participating provider."** "Participating provider" means any individual, group practice or institutional provider of any kind, that is qualified to participate in the Single Payer, that provides health care services under the Single Payer.
- **Private-pay patients.** A participating provider shall not solicit or accept payment from any Single Payer member or third party for any health care service covered by the Single Payer and provided to a patient with Single Payer coverage, except as provided under a federal program. This does not preclude the Single Payer from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.
- **Rate restrictions.** A participating provider shall not charge any rate in excess of the rates established by the Single Payer for any health care service covered by the Single Payer.

APPENDIX A

High Level Overview of Key Existing Efforts Focused on Health Care Workforce

The Oregon Health Authority is engaged in a variety of efforts to ensure that the state has an adequate supply of health care providers and to achieve a more equitable distribution of providers across the state. Current work at OHA falls into four broad buckets: Analysis to better understand the supply; distribution, and diversity of the existing workforce; provider incentive programs to better achieve supply, distribution, and diversity goals; community-based initiatives to develop a health care workforce that meets the needs of the state; and new initiatives focused on Oregon's Behavioral Health workforce.

In recent years, the Legislature has increased investment in OHA's workforce-focused activities, and these investments are informed by and created new reporting and analysis requirements that help Legislators, communities, and others better understand the state's existing health care workforce.

Conducting or Supporting Workforce Analysis

The Primary Care Office (PCO) supports and conducts assessments and analyses of the health care workforce in the state. Key products include a biennial Health Care Workforce Needs Assessment, which is used as a basis for distributing more than $19 million in incentive funds to health professionals, and the biennial Workforce Diversity Profile, developed by the Office of Health Analytics, which provides a comprehensive look at the gender, ethnic, and linguistic diversity of the health care workforce. Also, PCO is tasked with conducting analyses of the health care workforce capacity in different areas of the state against federal standards, which provide access to federal recruitment and retention incentives. Key pieces of research and analysis include:

- Health Care Workforce Needs Assessment – developed by OHA every other year and submitted to the Oregon Legislature in advance of the long-session which meets in odd numbered years
- Health Workforce Diversity Report – developed by OHA every other year at the direction of the Oregon Health Policy Board's Workforce Committee
- Health Professional Shortage Area (HPSA) analysis – developed in an ongoing/intermittent fashion, generally every 2-3 years but potentially more often based on community demand

Overseeing and Coordinating Provider Incentives

PCO oversees more than $19 million in the 2021-23 biennium in direct incentives to both licensed and non-licensed health professionals, and for health professional students—to work and remain in communities that experience health inequities. Additionally, the office serves as the state point-of-contact for federal incentive programs, including the National Health Service Corps, which provides scholarships and loan repayment for currently more than 470 Oregon providers practicing primary care, oral health and behavioral health. The PCO provides assistance for clinics to qualify for the program and enable their providers to apply for these resources.

- Federal Incentives—
    - The PCO assists with certification/recertification/qualification for federal funding
    - Supports clinicians with placement efforts

- State Incentives—
    - $18M Health Care Provider Incentive Program uses a variety of strategies to invest in Oregon's health care workforce including:
        - Loan repayment
        - Rural provider insurance subsidies
        - Scholarships
        - Loans/Loan Forgiveness

Funding Community-Based Initiatives

The Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program, provides approximately $14 million over a biennium to help fund community-based initiatives to expand training of health professionals and diversify the workforce. Currently, OHA is funding 18 projects throughout the state, across disciplines. Projects include a dental health professions camp at Clackamas Community College for high school students with an interest in a career in oral health, three new primary care residency programs (on the Central Coast, in Douglas County and in Central Oregon), and resiliency training for behavioral health professionals throughout the state.

New Behavioral Health Workforce Initiative

In the 2021 Session, the Oregon Legislature dedicated $80 million of federal Rescue Plan funding to support a Behavioral Health Workforce Initiative, to help diversify the behavioral health workforce, ensure culturally responsive behavioral health service to particularly support those from communities that have experienced health inequities, and to grow the workforce through support of clinical supervision and moving providers-in-training through to licensure at a faster pace. This initiative will be led by the Health Systems Division of OHA, with collaboration from the Health Policy & Analytics Division, to take advantage of the expertise of the PCO as it relates workforce development.