Small Market Communities:

Challenges and Opportunities in Serving OHP Enrollees and the Uninsured

August 2002

Oregon Health Policy and Research

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Introduction

Staff from the Office for Oregon Health Policy and Research visited several Oregon counties to explore how Oregon Health Plan (OHP) enrollees and the uninsured access health care services in "small markets." This paper identifies characteristics of health care delivery systems in those counties and the influence these characteristics have on the provision of care.

Several aspects were explored:

- Health care practitioner participation
- Factors that influence the viability of an OHP Fully Capitated Health Plan in small markets
- Roles of health care safety net clinics in the provision of care

For the purpose of this report, a small market is defined as a county with a population base of less than 100,000 residents and a minimum of 13% of the residents enrolled in OHP. While 27 of Oregon's 36 counties fit these criteria, six counties are included in this summary—Baker, Coos, Curry, Jefferson, Josephine, and Union Counties. Additionally, representatives from Linn, Benton, and Jackson Counties were visited to gain a further understanding of the strengths and challenges of a Fully Capitated Health Plan (FCHP) contracting to serve Oregon Health Plan enrollees.

Prior to the 1989 OHP enabling legislation (Senate Bill 27), Oregon had a long history of managed care in the commercial sector.

Medicaid Managed Care in Oregon

Prior to the 1989 OHP enabling legislation (Senate Bill 27), Oregon had a long history of managed care in the commercial sector (Kaiser Permanente originated in Oregon and Southern Washington in the 1940s) and several years of experience with Medicaid managed care.[5] Oregon's Medicaid managed care system was once based on Physician Care Organizations (PCO), a partial-capitation model that could be organized and administered locally, and was viable with as few as 500 Medicaid enrollees. Under the PCO model, physicians were paid through capitation while hospital services and prescription drugs were paid by the state

using traditional fee-for-service (FFS). There was also a "risk-sharing" arrangement between the state and the PCO. When OHP was implemented in 1994, Physician Care Organizations were phased out in favor of fully capitated health plans. Furthermore, Federally Qualified Health Centers and Rural Health Clinics, previously entitled to cost-based reimbursement by the State, no longer were assured enhanced reimbursement for people enrolled in OHP FCHPs.

When OHP was implemented in 1994, Physician Care Organizations were phased out in favor of fully capitated health plans.

OHP expanded the use of managed care by requiring enrollees to choose a FCHP, unless one was not available in the enrollee's county.[19] Because a FCHP was the preferred delivery model to assure health care access for OHP enrollees, the State of Oregon designed a variance in payment levels between FCHP premium rates and FFS payments. FCHP premiums would more closely reflect the cost of care while FFS payment levels remained at their previous (and lower) levels. The State presumed that this reimbursement differential would provide incentive for FCHPs and health care providers to expand managed care to new communities. By 1996, all but three counties in Oregon had the presence of an OHP FCHP. Encouraged by the thousands of new enrollees coming into OHP and by Oregon's explicit reliance on FCHPs, commercial insurance sponsored FCHPs expanded rapidly into new communities and PCOs were phased out.

By 1998, it became apparent that commercial insurance sponsored FCHPs could not continue to expand into all of Oregon's communities, especially the "smaller markets." Meanwhile, local organizations were being developed specifically to enter into FCHP contracts with the State of Oregon. By 2000, the OHP delivery system had shifted away from commercial insurance sponsored FCHPs, and relied more heavily on community based FCHPs that were locally built, owned, and controlled.[5]

OHP Health Care Delivery System

Although financing, insurance, delivery, and payment are basic functions of the health care delivery system,[18] there is great variety among the systems providing health care services to OHP enrollees. Some

communities have a fully capitated health plan (FCHP), while others have Primary Care Case Managers (PCCM), or traditional fee-for-service (FFS). Still other counties have combinations of the three delivery system models.

Fully Capitated Health Plans

Oregon continues to rely, in large part, on the participation of FCHPs in order to provide health care services to people enrolled in the OHP. An OHP FCHP contract requires an identified range of primary and acute care services in exchange for a set per-member per-month (PMPM) fee.[19] FCHPs are at full financial risk and directly accountable for all covered medical benefits. More than 60% of OHP enrollees are enrolled in a FCHP.[20] Only six Oregon counties do not have a FCHP serving people enrolled in OHP; 15 counties have only one FCHP.[20] Although all FCHPs are responsible for the finance, insurance, provider payment, and delivery of health care to OHP enrollees, there is organizational diversity among Oregon's FCHP contractors.

Oregon continues to rely, in large part, on the participation of FCHPs in order to provide health care services to people enrolled in the OHP.

For example:

- The Mid-Rogue Independent Practice Association (MRIPA) serves several southern Oregon counties, including Josephine County, and covers a total of 5,668 OHP enrollees. Doctors of the South Coast (DOCS) in Coos County, another example of an independent practice association (IPA), covers 7,969 people enrolled in the OHP. IPAs are owned and governed by physicians and are paid either on a capitation or a modified FFS basis. IPAs allow physicians to determine practice and utilization management approaches, reimbursement fees, and strategies to control expenses.

- Intercommunity Health Network (IHN). IHN is owned by Samaritan Health Services, which owns six hospitals and one assisted living facility in Oregon's Mid-Willamette Valley. IHN, a Management Services Organization (MSO), has a FCHP contract with the State and serves 15,729 OHP enrollees. An MSO is owned by a hospital, physician organization, or a third party. The MSO contracts with payers, hospitals and physicians to provide services such as

negotiating fee schedules, handling administrative functions, and billing and collections.

- Central Oregon Integrated Health System (COIHS) is a Physician Hospital Organization (PHO) with an OHP contract that is owned by physicians (60%) and a group of hospitals in its service area (40%). COIHS serves 22,739 OHP enrollees in 11 counties throughout central Oregon including Jefferson County. PHOs are owned jointly by a hospital and a physician group that, in turn, contract with hospitals and physicians for the delivery of services to payers under contract to the PHO. It can also provide management services and perform other services typically associated with an MSO.

- It is worth noting that a "hybrid" of the above models also can offer the needed structure to deliver health care services to OHP enrollees. CareOregon, exclusively serving OHP enrollees, was created in 1993 by a partnership between Multnomah County Health Department, Oregon Primary Care Association and Oregon Health and Sciences University.[2] It is the largest OHP FCHP. CareOregon works closely with health care safety net clinics and other providers throughout Oregon, serving more than 87,000 OHP enrollees in 17 Oregon counties.

To provide some management of health care services, Oregon offers the primary care case manager program.

Primary Care Case Managers

The State does not have a contract with FCHPs for OHP enrollees in all Oregon communities and existing OHP FCHPs have limited capacity. To provide some management of health care services, Oregon offers the PCCM program. In this delivery system model, the State of Oregon provides the financing, insurance, and payment of health care services provided to OHP enrollees.

An OHP PCCM offers primary care services on a FFS basis and is responsible for referral of OHP enrollees to specialists and other providers. PCCM services include comprehensive, ongoing assessment of medical needs plus the development and implementation of a plan to obtain other needed medical services.[14] PCCM places health care

providers at minimal financial risk and imposes less administrative complexity than a FCHP. In all but one of Oregon's counties, some OHP enrollees have a PCCM. The State of Oregon offers a monthly fee of $6 per OHP enrollee for a PCCM to provide access to health care services and coordinate their care. In June 2002, about 3% of OHP enrollees (almost 14,000 Oregonians) accessed the delivery system through a PCCM.

Fee-For-Service

Thirty-five percent of OHP enrollees (more than 153,000) are not enrolled with either a FCHP or PCCM.[20] They use an OHP "open card." The effectiveness of an open card depends upon an OHP enrollee's ability to find a health care practitioner who is willing and able to provide and coordinate care. In this type of delivery system, the financing, insurance and payment are provided by the State of Oregon. The State also participates in the delivery of care by providing health care protocols, pre-authorizations and other utilization management tools. Providers receive FFS reimbursement, in contrast to the FCHP model, where services are covered by a fixed advance payment that is independent of the number of services provided.

Although an FCHP is an effective and efficient means of providing access to and managing costs of health care, the prosperity of a community based FCHP serving a small Oregon community cannot be assured.

Challenges and Opportunities

Community Based Fully Capitated Health Plans

One of the original intents of OHP was to reduce the use of the fee-for-service (FFS) payment system; based on the supposition that FFS encourages utilization of unnecessary medical services. OHP expanded the use of fully capitated health plans (FCHP) by requiring OHP enrollees to join, unless no FCHP was available in the enrollee's county. By the late 1990s commercial insurance sponsored FCHPs were no longer flourishing and more locally built, owned, and controlled FCHP were serving OHP enrollees. Although a FCHP is an effective and efficient means of providing access to and managing costs of health care, the prosperity of a community based FCHP serving a small Oregon community cannot be assured.

Several areas should be considered when evaluating the potential success of a community based OHP FCHP:

- ***Infrastructure:*** Infrastructure needed to support an OHP FCHP includes administering claims, securing reinsurance (stop-loss insurance), managing pharmacy benefits activities, contracting with health care providers, assuming financial risk, and participating in OMAP trainings, meetings, and other activities.
- ***Provider structure:*** In order to become a FCHP contractor, health care providers must structure themselves. Structures include but are not limited to an IPA, MSO, and PHO.
- ***Provider capacity:*** An adequate number of health care providers willing and able to accept OHP enrollees are necessary to create and sustain a FCHP. The ability to match capacity (supply) with enrollment (demand) is crucial to the success of a FCHP.
- ***Community interest:*** A core of community stakeholders, who believe that a FCHP is advantageous to OHP enrollees, as well as practitioners, is needed to develop and maintain a FCHP.

These characteristics are critical to the success of a community based FCHP. Many small Oregon communities lack one or more of these criteria and the confidence that a FCHP contract in their community will be financially advantageous and/or yield positive health outcomes. Some providers choose to participate in a contractual risk sharing agreement with a FCHP that is not based in their community. Central Oregon Integrated Health System (COIHS) and CareOregon are FCHPs that have developed and sustained relationships in multiple small markets. Their success is due, in part, to efficient and effective administrative infrastructures as well as their relationships with providers in small Oregon communities.

Although many practitioners provide health care services to OHP enrollees and the uninsured, they expressed concern about their ability to continue doing so.

Financial Impact on Practice and Practice Management

The cost of operating a medical practice continues to rise, challenging health care providers in small Oregon communities. Although many practitioners provide health care services to OHP enrollees and the uninsured, they expressed concern about their ability to continue doing

so. Interviewees identified malpractice insurance, inadequate reimbursement rates and staff compensation as issues threatening provider participation in OHP and caring for the uninsured.

The rising costs of malpractice insurance and the (un)willingness of malpractice insurers to underwrite health care practices impacts access to health care. At the 2002 Oregon Medical Association's Annual Meeting it was reported that the growing crisis is in large part due to rising settlements in malpractice cases. In January 2001, one of the state's few malpractice insurance carriers announced it would not "write new business" involving obstetrical care. In 2002, another carrier raised overall rates by an average of 60%. The rising costs or lack of available malpractice insurance challenges providers so much that some practitioners, especially obstetricians, are moving to other states where malpractice insurance costs are significantly less.[21] Remaining practitioners warn that they will either leave the state or change their scope of practice unless conditions change. Oregon realizes the significance of the malpractice crisis and has formed a task force to examine the problem and potential solutions.

The costs of managing a hospital or medical practice continue to rise, challenging practitioners in small communities.

Although providers in small communities frequently want to serve all members of their community in need of care, it is difficult to do so and be a solvent practice. Interviewees indicated that OHP reimbursement is significantly lower than commercial rates. OHP reimbursement does not cover the entire cost of the provided health care let alone the actual charges of that care. Furthermore, Oregonians who are uninsured and low-income frequently lack the funds to pay the total charges of health care services.

The costs of managing a hospital or medical practice continue to rise, challenging practitioners in small communities. For example, providing adequate compensation to recruit and retain qualified staff continues to challenge practices. Workforce shortages allow health care professionals to obtain significantly higher wages thus adding to a provider's overhead cost.

Hospital Role

Most small communities have an acute care hospital, providing a number of services including emergency care services. Often these hospitals are among the largest employers in the community providing employment and benefits to residents of the community.

. . . there are insufficient numbers of health care providers serving people with no health insurance or enrolled in the OHP . . .

Acute care hospitals serving small markets often have a Type A, B, or Critical Access Hospital designation. These designations enable certain rural hospitals to improve their financial stability through enhanced reimbursement and reduced operating costs. Hospitals are paid the costs of services provided as opposed to being paid a pre-established fixed amount per episode of care. This is called "case based" reimbursement and is used to pay hospitals for services provided to OHP enrollees (as well as Medicare). Reimbursement varies based on a ratio of cost to charges that is established by annual cost report settlements. Because these designated hospitals are reimbursed the relative cost of care, small communities have access to tertiary health care services. No risk is assumed by the hospital for providing services and thus hospitals have little incentive to develop or participate in a FCHP contract.

Health Care Workforce

Interviewees from each community expressed that there are insufficient numbers of health care providers serving people with no health insurance or enrolled in the OHP, especially primary care physicians and obstetricians. This is a deterrent to the goal of providing care for all members of a community, particularly enrollees in OHP and the uninsured. Programs exist that are designed to encourage practitioners to serve in small Oregon communities.

For example:

- Some small Oregon communities apply for and receive special federal designations such as "health professional shortage area" (HPSA), "medically underserved area" (MUA), or medically underserved populations (MUP).[13] Designations are based on unmet health care needs and provide an opportunity to develop a rural

health clinic, federally qualified health center, and/or participate in the National Health Service Corps (NHSC).

- The NHSC helps medically underserved communities recruit and retain primary care clinicians, including dental and mental and behavioral health professionals, to serve in their community, and offers a loan repayment program.[12] Furthermore, practitioners in rural communities and/or working for Type A or B hospitals have the ability to receive grants up to $5,000 as personal income tax credits.[13]

- Oregon's Office of Rural Health (ORH) offers the Oregon Rural Health Services Program (RHS), which encourages physicians, nurse practitioners, and physician assistants to practice in rural communities. RHS offers up to $25,000 for student loan principal payment in exchange for providing health care services in communities in 27 Oregon counties.[13] Furthermore, the Health Care Experts for Rural Oregon (HERO) is an ORH program created to bring health care providers to underserved areas of rural Oregon. The program has helped rural communities in 28 Oregon counties recruit and retain more than 100 health care practitioners since 1994.

- To address the nursing shortage, the federal FY 2003 budget proposes $15 million to expand the Nursing Education Loan Repayment program. The increase will support 800 new nursing education loan repayment agreements.[6]

- The J-1 Visa Waiver Program and the Conrad-20 Program are two other options designed to address health care provider shortages. Both programs enable international medical graduates to stay in the United States after graduation from their residency program if they practice in a federally designated HPSA, MUA, or MUP. Following the events of September 11, 2001 there is increased concern about non-citizens living and working in the United States. The federal government is not processing and reviewing new J1 Visa applications as it did in the past. Thus, the future of the J1 Visa program is uncertain.[9] Oregon, however, is pursuing Conrad-20 for the first time. Under Conrad 20, Oregon may submit as many as 20

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applications for Visa waivers annually to the federal government. It is anticipated that Oregon's Conrad-20 Program will be operating by Fall 2002.

Health Care Safety Net Clinics

The presence of a health care safety net clinic in a small Oregon community improves access to medical services, especially for those who are uninsured or enrolled in OHP. Oregon's health care safety net is comprised of a broad range of local non-profit organizations, government agencies, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing needed health care services. Health care safety net clinics provide primary health care and preventive services regardless of a person's ability to pay. They are often recognized for their culturally and linguistically appropriate services and ability to serve underserved communities.

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Safety net clinics include, but are not limited to:

- Rural Health Clinics
- Federally Qualified Health Centers
- Indian and Tribal Health Clinics
- School Based Health Centers
- Public Health Departments
- Community Based Health Clinics

Recently, the "President's Initiative" was outlined which would double the capacity of the health care safety net and provide 1200 communities with new or expanded health centers by 2006. Furthermore, the Administration's budget for fiscal year 2003 requests an increase of $114 million for health centers that would support 170 new and expanded health center sites and provide services to one million additional patients.[11]

Several interviewees identified the value of a health care safety net clinic but stressed the importance of the clinic not competing with other

providers in the community. In Baker City health care professionals, St. Elizabeth Health Services, and other community stakeholders, have been working with the Office of Rural Health and the Oregon Primary Care Association to explore the development of a health care safety net clinic. Other visited communities are exploring the possibilities of developing a health care safety net clinic to improve health care access for low income Oregonians.

Attaining RHC or FQHC status has advantages and disadvantages. The primary advantage is the Medicaid prospective payment system (PPS), which was enacted into law as part of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.[1] PPS is an enhanced reimbursement rate received for providing OHP (and Medicare) services in medically underserved communities and health professional shortage areas. The primary disadvantages of RHC or FQHC status can be the sometimes competitive, complex, and on-going qualification process, delay of obtaining funding, and a lack of understanding of the programs by fiscal intermediaries, States, and the Centers for Medicare and Medicaid Services (CMS).

Many small Oregon communities have created innovative arrangements with both public and private partners to improve access to health care services.

Community Partnerships

Many small Oregon communities have created innovative arrangements with both public and private partners to improve access to health care services. Although, no single community partnership guarantees access to comprehensive and coordinated services for all people in a community, such partnerships significantly increase the likelihood that people will receive needed medical care.

Innovative examples include:

- The Union Family Health Center, a Rural Health Clinic, was created because the local public school system, local government, OHSU School of Nursing at Eastern Oregon University, and community members wanted to improve health care access in their community.
- VolPact is a partnership between the Jackson County Medical Society, local hospitals, and health care providers. VolPact makes

medical and hospital services available to people who are uninsured and with limited or no financial resources.

- The Health Care Coalition of Southern Oregon (HCCSO) promotes the health of low-income Oregonians in Jackson, Josephine, and Douglas Counties through a formalized system of collaboration. HCCSO is committed to reducing barriers to health care services. They help health care safety net providers develop and implement comprehensive health care delivery for people who are medically indigent.

. . . inadequate access to health care services negatively impacts the entire community.

Community Commitment

Hospitals, health care safety net clinics, private practitioners, health plans, and other community partners who recognize the importance of a dependable delivery system and are willing to collaborate can improve health care services to people who are uninsured or enrolled in OHP. It is essential that a community values the health of their community and recognizes that inadequate access to health care services negatively impacts the entire community.

A community leader with a vision and the willingness to "champion" an effort needs to foster community commitment. A champion will recognize the challenges and opportunities in providing health care to the entire community and work with unlikely partners such as business, social service providers, faith-based organizations, and schools in order to improve access to needed health care services. Although there may not always be agreement, a champion will realize that a shared vision and commitment can improve access to health care services.

Summary of Findings

In all the communities visited similar comments were expressed about the challenges of providing continuous and comprehensive health care services for those who are enrolled in OHP or uninsured. According to

site visits and key informant interviews with medical providers, representatives of fully capitated health plans, and other community leaders in small Oregon communities:

- It is essential to identify, respect and build upon the uniqueness of each Oregon community.
- Insurance does not guarantee access to needed medical care for all OHP enrollees.
- Each community offers health care services to those who are uninsured or enrolled in OHP, but none of the communities contacted offer continuous and comprehensive health care services to everyone living in that community.
- The benefit structure of the Oregon Health Plan should be modified before seeking additional concessions from the provider community. While reimbursement for OHP FCHP enrollees is more than FFS reimbursement, both tend to be insufficient.
- Community based fully capitated health plans are a viable option in some communities; they do not work in all communities. Alternative approaches to providing health care services to people enrolled in OHP and the uninsured need to be explored and supported.
- The administrative rules of a FCHP contractor are perceived less burdensome than the administrative rules of the State's FFS but overall providers find OHP to be administratively burdensome.
- Cost based reimbursement for hospitals in small communities provides financial stability to the hospital and helps ensure that acute and hospital outpatient services are available in smaller Oregon communities.
- The rising cost of medical malpractice insurance and the unwillingness of malpractice insurers to underwrite health care practices negatively impact the ability of practitioners to remain in small communities.

Alternative approaches to providing health care services . . . need to be explored and supported.

- Health care practitioners are committed to serve patients regardless of an ability to pay but are increasingly challenged in doing so.
- Health care safety net clinics are an important point of access to health care services for OHP enrollees as well as people without health insurance in small Oregon communities.

Recommendations

Support local efforts to improve access to health care services.

The State should support local efforts to improve access to health care services to people enrolled in OHP and those who are uninsured. Each Oregon community is unique and has its own strengths and challenges. The State needs to work with a diverse mix of local stakeholders to determine how best to assist specific communities.

The State needs to work with a diverse mix of local stakeholders to determine how best to assist specific communities.

The State of Oregon should provide technical and financial resources to support local community efforts to develop and operate health care safety net clinics and work to ensure that such clinics are incorporated in the OHP delivery system. Health care safety net clinics play an increasingly larger role in delivery systems throughout Oregon's small communities. Many health care safety net clinics participate in an OHP fully capitated health plan, accept fee-for-service (FFS) patients, and partner with public and private stakeholders to deliver health care services and create innovative solutions to local health care issues.

Since health care safety net clinics serve a disproportionate number of low-income uninsured people, the State should continue to pay an enhanced reimbursement rate to FQHCs and RHCs. At the same time, the State should explore additional and alternative delivery and funding strategies that increase health care access for low-income Oregonians and support health care safety net clinics that are not federally designated.

The State of Oregon should also continue to support the cost based reimbursement of appropriately designated hospitals in small markets. These hospitals rely on an enhanced reimbursement rate so they can

serve the local community both as a provider of care and as a major employer. The State should continue to work with these hospitals to develop case management approaches that ensure appropriate utilization of acute care services.

Encourage local delivery systems that promote access to health care services, case management, cost effectiveness and adequate reimbursement.

Where local providers are participating in or express an interest in participating in an OHP FCHP contract, the State of Oregon should support that approach. Each small community should have an OHP managed care arrangement as well as FFS care available to OHP enrollees. In other communities where no OHP FCHP exists and there is no local support to develop or enter into an OHP FCHP arrangement, the State needs to support an alternative managed care approach such as PCCMs or PCOs.

The State should encourage all providers in a small community to share the responsibility of providing access to health care services to all people in their community.

The State should provide support and information to local providers in order to assist with service utilization management for OHP enrollees. In many small market communities, the health care delivery systems tend to focus on the provision of health care services rather than the financing of health care. For example, a prior authorization program for high cost procedures could be designed and implemented in partnership with PCCMs.

The State of Oregon should encourage innovative public-private partnerships to provide case management for OHP enrollees. The State could work with a local public health department, safety net clinic, private practitioners, and hospital to provide and manage health care services to the uninsured and OHP enrollees in a small community.

The State should encourage all providers in a small community to share the responsibility of providing access to health care services to all people in their community. Strategies to sustain and/or increase provider participation in OHP include effective and frequent communication, increased provider reimbursement, and taking on the malpractice insurance crisis.

Streamline administrative requirements for OHP

The State of Oregon should work with health care providers to reduce the administrative complexities of serving OHP enrollees. For example, the State could work with providers in small communities with no OHP FCHP contract to determine how administrative regulations may be modified to encourage greater participation in the PCCM program.

Administrative rules related to FFS could be also modified to assure that OHP enrollees are receiving appropriate and cost effective care. Since providers assume little to no financial risk when caring for OHP enrollees who are FFS, administrative rules should be more rigorous than in managed care and yet sufficient to assure quality and appropriate services.

Conclusion

The provision of quality health care remains uniquely local.

Several themes were identified in all the communities visited. All health care practitioners reported that they care for people who are uninsured or enrolled in OHP. Many noted that their ability and willingness to continue doing so is at risk, primarily due to OHP's inadequate reimbursement rates and administrative complexities. A number of Oregon communities are creating public and private partnerships to pursue alternative strategies to deliver care to those who are uninsured or on OHP. Many communities either rely on, or are exploring the option of developing a health care safety net clinic, in order to improve access to health care for those who are uninsured or on OHP.

It is essential to recognize the uniqueness of each community. Oregon's small communities have challenges and potential strengths that differ from larger metropolitan areas. While a small community may not have the financial support, established infrastructure, or desire to develop an OHP FCHP contract, they do have the ability to mobilize community partners and a commitment to serve their community. These strengths can enhance a small community's ability to develop a model of health care delivery that meets the needs of its community residents. The provision of quality health care remains uniquely local.

Small Market County Profiles

Baker

Coos

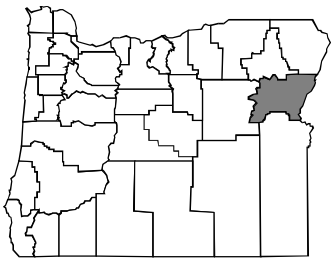
Curry

Jefferson

Josephine

Union

Baker County



Location: Eastern Oregon, 300 miles east of Portland, on the Idaho border

Population: 16,741 reside in the county, which covers 3,088 square miles. Almost 60% of the county residents live in Baker City, which is the county seat.[16]

Economy: Agriculture, forest products, manufacturing and recreation.

Key demographic features: 41% of residents live below 200% of the federal poverty level (FPL).[8] 12.3% are unemployed.[17] Over 95% of the county is white, 2% Latino/ Hispanic origin.[7] Median age is 42.7; 24.2% under age 18 and 19% over 65.[16]

OHP and uninsured: Close to 15% of the county residents are uninsured.[8] More than 13% of the county residents (2,208) are enrolled in the OHP. 499 are enrolled with a PCCM and 1,884 have an OHP open card.[20]

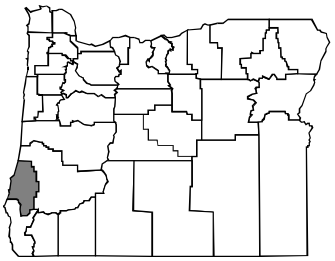
No OHP FCHP serves any community in Baker County. Baker County residents enrolled in OHP or uninsured tend to access health care services through private practitioners' offices and Baker County Public Health Department. The Baker County Health Department offers access to school health clinic services, community health nursing, immunizations, Women, Infant & Children Nutritional Program (WIC), environmental health, and other prevention activities. Furthermore, St. Elizabeth Health Services is a Type A hospital located in Baker City. St. Elizabeth offers emergency services, medical/surgical services, radiology, laboratory, home health, and other health services.

Perspectives on access to continuous and comprehensive health services for the uninsured and OHP enrollees vary. Local providers tend to believe that developing a community based FCHP would not improve access to

health care. Interviewees also repeatedly expressed concern about OHP administrative complexities and that OHP reimbursement does not cover the time, resources and technology needed to operate a FCHP, concluding that developing a FCHP is not wise endeavor at this time. OHP providers participate in the primary care case management (PCCM) program and receive $6 per member per month per enrollee in addition to FFS reimbursements. Although the PCCM program offers a $6 "incentive" to serve people enrolled in OHP, some claim that PCCM processing costs more than the payment received.

A diverse group of Baker County residents are working collaboratively to complete the Community Health Improvement Plan (CHIP) with the assistance of Oregon's Office of Rural Health. One strategy identified to improve access to health care is creating an affordable basic health insurance package for the uninsured in Baker County. Furthermore, Baker City is designated a medically underserved area (MUA/P) and therefore some residents are exploring health care safety net clinic options that may improve access to health care services.

Coos County



Location: Oregon's southern coast, borders Curry and Douglas Counties

Population: 62,779 reside in the county, which covers 1,806 square miles

Economy: Agriculture, forest products, fishing, hunting, and tourism.

Key demographic features: 55% of residents live below 200% FPL[8]; 10.1% are unemployed.[17] 92% of county residents are white, 2.4 % Native American/Alaska Native with all other races representing less than 1% of the total population. Just more than 5% of Coos County residents are Latino/Hispanic.[7] Median age is 43.1; 21.9% under age 18 and 19.1% over age 65.[16]

OHP and uninsured: 18% of county residents are uninsured.[8] 15.7% of county residents (9,864) are enrolled in OHP. 8,037 residents are enrolled in an OHP FCHP, 201 have a PCCM, and 1,626 use an OHP open card.[20]

Most medical providers in Coos County share the responsibility of providing access to health care services to OHP enrollees and the uninsured. There are three hospitals in Coos County. Southern Coos Hospital and Health Care Center, located in Bandon, has 21 beds, general acute care, outpatient services, home health, and a 24-hour emergency department. Bay Area Hospital is a publicly owned facility located in Coos Bay and provides full hospital services including medical, surgical, mental health, pediatric, critical care, and home health services as well as a cancer treatment center. Coquille Valley Hospital, located in Coquille, is a 30-bed district hospital providing full services including acute care, emergency department, outpatient services, home health care, and other services.

Doctors of the Oregon Coast South (DOCS), is a fully capitated health plan that serves OHP enrollees living in Coos County. Most health care providers in Coos County participate in DOCS and yet it has reached its capacity or near capacity to serve OHP enrollees due to a limited number of primary care physicians. Interviewees suggest that a community based FCHP is an effective model for their community that helps ensure access to health care services, quality care, and is more cost-effective than the FFS approach.

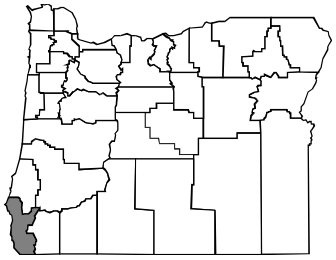
Coos County interviewees expressed concern that OHP reimbursement is inadequate and may negatively impact access to care for OHP enrollees. Furthermore, interviewees encouraged the State to offer OHP to more Oregonians by reducing the scope of benefits currently offered.

Additionally there is the Waterfall Clinic, a community based health care safety net clinic that serves the uninsured. The clinic was started by a physician member of the North Bend Medical Clinic and works in cooperation with Bay Area Hospital in Coos Bay. It is staffed part-time by a Nurse Practitioner with support from the founding physician. Some community stakeholders indicated that although the Waterfall Clinic provides an important safety net for low-income uninsured residents, it would be unwise to expand the clinics capacity much more. It was reported by some that an expansion could reduce the need for people to enroll in OHP and may create duplicative services. Other stakeholders, however, indicated that a health care safety net clinic would improve health care access in Coos County.

Another point of health care access is the Coquille Indian Health Center. This health care safety net clinic is on Tribal reservation land in Coos Bay and provides culturally specific services. The Health Center has an outpatient clinic with three exam rooms, one treatment room, and pharmacy and optometry services. The Health Center also houses all Coquille Tribal Human Services Programs and Contract Health Services. Coquille Indian Tribal Human Services Programs include: direct care, pharmacy, optometry, Business Office, Contract Health, Community Health, Indian Child Welfare, Alcohol and Drug, Child-Care, General Assistance, Health Promotion/Disease Prevention, Youth and Elder's Activities, Mental Health, and Foster Care.[10]

Furthermore, the Coos County Health Department is a point of health care access. The Health Department offers community health nursing, family planning, Women, Infant and Children Nutritional Program (WIC), environmental health, and other prevention activities.

Curry County



Location:	Southwest corner of Oregon, where the Rogue and Chetco Rivers meet Pacific Ocean; borders California
Population:	21,137 reside in the county, which covers 1,989 square miles
Economy:	Government (education, health and social services), agriculture, fishing, tourism, and retail.
Key demographic features:	62% of residents live below 200% FPL;[8] 8.5% are unemployed.[17] 93% of residents are white, 2.1 % are Native American/Alaska Native, and all other races represent less than 1% of the county's population. Just above 3% (3.6%) of the population is Latino/Hispanic (of any race).[7] The median age is 48.8 years of age; 19.2% under age 18 and 26.6% over 65.[16]
OHP and uninsured:	15% of the county's residents are uninsured.[8] 13% of the county residents (2,779) are enrolled in OHP. There are no people enrolled in an OHP FCHP, 106 people have a PCCM, and 2,673 have an OHP open card.[20]

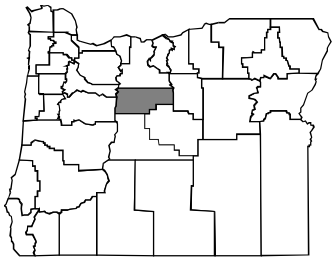
Access to health care services is limited, especially for Curry County residents who are uninsured or enrolled in OHP. Health care services are available at Curry General in Gold Beach. Curry General is a Type A 24-bed, acute-care medical facility established in 1951. The hospital includes a 24-hour emergency department, medical-surgical facilities, obstetrics, medical laboratory and radiology. Curry General is operated by the Curry Health District, in addition to Curry Family Medical, a full-service medical clinic in Port Orford and The Brookings Clinic, a walk-in clinic with evening and weekend hours. Curry County has a RHC, Oak Street Health Center, located in Brookings. The Oak Street Health Center holds evening hours. Some interviewees indicated that

additional or expanded health care safety net clinics may increase access but they were currently prioritizing provider recruitment and other delivery expansion strategies. Curry Health District also owns Shore Pines, a 43-unit assisted living facility.[3] The district is a major employer with 100 employees, and $3.1 million in payroll. A five-year general obligation bond was approved by district voters in 1998, allowing it to borrow the capital necessary to purchase expensive high-tech equipment and maintain the facility.[4]

Although Curry County providers previously participated in an OHP FCHP, they are not currently part of an OHP FCHP arrangement. According to some, the prior capitated arrangement almost bankrupted the hospital. Interviewees reported that more cooperation exists among health care providers to care for OHP enrollees since the exodus of the FCHP. Health care providers are confident that FFS is the most appropriate approach to ensuring access to health care for the OHP enrollees in their community. The hospital is more financially stable without a FCHP and reimbursed on a "cost to charge" ratio and access, while still limited, is better than it was when there was a FCHP.

Another point of access for is the Curry County Health Department. The Curry County Health Department offers services, such as community health nursing, family planning, Women, Infant and Children Nutritional Program (WIC), immunizations, environmental health, and other prevention activities.

Jefferson County



Location: In central Oregon.

Population: 19,009 people reside in the county, which covers 1,791 square miles.

Economy: Agriculture, manufacturing, trades and services, tourism, as well as government (education, health and social services)

Key demographic features: 59.7% of county residents live below 200% FPL;[8] 8.6% are unemployed.[17] 69% are white, 15.7% Native American/Alaska Native, and 11.3 % identified as "other race"; 17.7% of the people are Latino/Hispanic (of any race).[7] Median age is 34.8; 29.8% under age 18 and 12.4% over age 65.[16]

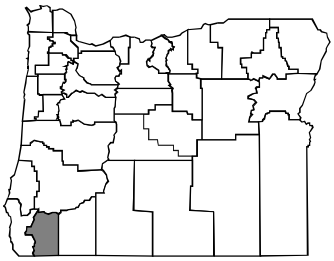
OHP and uninsured: 14% of county residents are uninsured.[8] 19% of county residents (2,196) are enrolled in a FCHP, 26 have a PCCM, and 1,413 have an OHP open card.[20]

COIHS is the sole OHP FCHP contractor, serving 60% of OHP enrollees living in Jefferson County. Although there is a health professional shortage in Jefferson County, local private practitioners make an effort to see all members of their community, including those enrolled in OHP or without health insurance. Mountain View Hospital District, an affiliate of St. Charles Medical Center, is a Type B Hospital located in Madras, the county seat. It is a full-care medical facility that provides a complete range of inpatient and outpatient services, including emergency care, surgery, radiology, mammography, physical therapy, and laboratory services. Mountain View also has an assisted living center. Despite local provider efforts, it was reported that access to prenatal health care and delivery services is inadequate and in jeopardy of becoming more scarce. The Jefferson County Health Department (JCHD) provides services to county residents in the areas of communicable disease control

(immunizations, TB testing, HIV counseling and testing), parent-child health (family planning, prenatal care, WIC) and environmental health (food protection, drinking water safety, rabies control). JCHD assists with the cost of care for uninsured pregnant women as well as makes referrals to private providers.

The Confederated Tribes of Warm Springs in conjunction with the Indian Health Service provides comprehensive direct health care services for tribal members, other federally recognized Indian tribes, and other appropriate members of the community. The Warm Springs Health and Wellness Center (Jefferson and Wasco counties are within the reservation boundaries) is owned by the Confederated Tribes of Warm Springs and provides medical and dental health care; counseling for substance abuse and mental health services. Support classes in nutrition, healthy cooking and exercise programs are provided to all patients. Home health, WIC, physical therapy and Healthy Kid's Program services are also available. Contract Health is provided to those living on the reservation or within a designated area and is paid by the Confederated Tribes. All direct dental and medical professionals are hired by the federal government. Five physicians and four dental professionals including a pediatric dentist work at the Health and Wellness center. A psychologist and psychiatrist staff the Community Counseling Center. The total patient population is approximately 5,750 annually.[10]

Josephine County



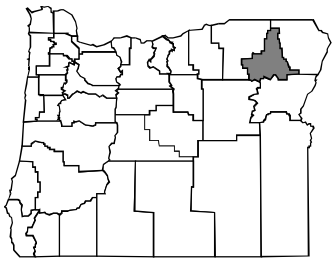
Location:	In Southern Oregon on the California border between Curry and Jackson Counties
Population:	75,726 people reside in the county, which covers 1,642 square miles
Economy:	Government (education, health and social services), manufacturing, retail, and tourism
Key demographic features:	42.3% of residents live below 200% FPL;[8] 8.6% are unemployed.[17] 94% of the residents are white and 1.3% Native America/Alaska Native. More than 4% of residents are Latino/Hispanic (of any race).[7] Median age is 43.1; 23.1% under age 18 and 20.1% over age 65.[16]
OHP and uninsured:	13% of county residents are uninsured.[8] 19.7% of county residents (14,935) re enrolled in OHP. 12,085 people are enrolled an OHP FCHPs; 162 have a PCCM, and 2,688 use an OHP open card.[20]

Both MR-IPA and Oregon Health Management Services (OHMS) are community-based organizations with OHP FCHP contracts. They are physician owned and controlled organizations with a solid and stable relationship with Three Rivers Hospital. Independent physicians formed MR-IPA while a group practice (Grants Pass Clinic) formed OHMS. Interviewees indicated that a physician owned and controlled FCHP model works better in Josephine County: It creates a better balance with the local hospital and the providers do not feel subjugated by the hospital. It was reported that although surplus is limited, MR-IPA uses any extra resources generated from its FCHP contract for physician recruitment and for development of information systems to improve connectivity and efficiency of the practice.

Three Rivers Community Hospital, a member of the Asante Health System, is located in Grants Pass. Three Rivers is a 98-bed full service facility with inpatient and outpatient services, including emergency care, surgery, radiology, cancer care, obstetrics services, home care and hospice, rehabilitation, and parish nursing outreach.

Josephine County residents also access health care at a variety of health care safety net providers including the Josephine County Health Department, which provides family planning services, perinatal services, WIC, dental care, parent child health programs, and other services. There are also two School Based Health Centers and the Siskiyou Community Health Center, an FQHC providing primary care services and improving health care access in Josephine County. The Siskiyou Clinic is a designated primary care provider who contracts with MR-IPA. Furthermore, the medical director of MR-IPA is the medical director of the Siskiyou Clinic. According to interviewees, the OHP works relatively well in Josephine County because the county medical community is primary care driven. Furthermore, it was stated that without the Siskiyou Clinic and the support of other primary and secondary care providers in Josephine County, access to health care would be very limited for OHP enrollees.

Union County



Location:	Eastern Oregon
Population:	24,530 people reside in Union County, which covers 2,039 square miles.
Economy:	Government (education, health and social services), manufacturing, retail, and tourism
Key demographic features:	36.2% live below 200% FPL;[8] 8% are unemployed.[17] More than 94% of county residents are white; no other race composes 1% of the entire county population although more than 2% of the population is Latino/Hispanic.[7] The median age is 37.7 and 24.6% are under 18 years and 14.7% are over age 65.[16]
OHP and uninsured:	8% of county residents are uninsured.[8] 14.5% (3,566) of the population is enrolled in OHP, 2,921 are enrolled in an OHP FCHP, 91 have a PCCM, and 554 use an OHP open card.[20]

There are a variety of points of access to health care services in Union County. Grande Ronde Hospital is the only hospital in Union County and serves as a referral center for Wallowa Memorial Hospital in Washington. Grande Ronde is one of the largest employers in eastern Oregon, employing over 400 people. It is a Type A hospital and comprised of 49 acute care beds, a 14 bed-transitional care unit, a Family Birthing Center, home health services including Hospice, and diagnostic and therapeutic outpatient services.

CareOregon is the sole OHP FCHP in Union County. Union County providers have welcomed CareOregon. Local practitioners reported that CareOregon has less onerous administrative rules than the state and therefore preferred over the "complexity and bureaucracy of the State." Furthermore, interviewees indicated that reimbursement is a "bit" better

from CareOregon than from open card. Providers reported a commitment to managed care and stated that "to return to a FFS system would be a step in the wrong direction."

Access to health care for people with no insurance is increasingly more difficult in Union County, according to local stakeholder interviews. One strategy to improve access for all Union County residents, including the uninsured, is the OHSU School of Nursing Nurse Practitioner program at Eastern Oregon University (EOU). It was reported that local physicians and the nurse practitioners are gradually accepting and working together. However, nurse practitioners are still not integrated into the entire delivery system.

One of the many accomplishments of the School of Nursing is their support and leadership in the development of a Rural Health Clinic and a School Based Health Center. The Union Family Health Center, an RHC, was developed through a unique public private partnership. Local leaders, the local school, local government, the School of Nursing at EOU, OHSU, and other local stakeholders joined together to build a health care safety net clinic in their own community. It was repeatedly reported that the clinic provides needed local access to health care services and that diverse members of the community donated their time and labor to develop and sustain the clinic's physical plant and equipment.

Union County Center for Human Development is a private not for profit organization that provides public health services such as tobacco prevention, WIC, immunizations, communicable disease control, community health nursing, a school health clinic, and mental health as well as alcohol and drug services.

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