March 13, 2013

To: Chair Greenlick and Members of the House Health Care Committee

Re: HB 2132-1 Public Hearing

I'm currently employed with Oregon Health and Science University Family Medicine at Richmond Clinic as a Medicaid Specialist/ Contracted Outreach worker. The majority of my work is with the low income, underinsured, Medicaid and Medicare populations.

This is a critical time in health care for our patients. I believe it is very important for the committee to consider developing policy and procedures that will assure primary care continuity.

We do not have experience with the function of the Health Insurance Exchange (Cover Oregon) because it hasn't started as yet. I do have experience with a myriad of patient experiences with patients being changed from one Managed Care Organization to an Open Card and back to an entirely different Managed Care Organization. This is extremely difficult on our patients and develops a high level of anxiety on already very ill individuals and can be seen as a current example of churn that can be indicative of challenges facing future patients transitioning between plans.

Please note these three OHSU patient experiences:

- New Liver transplant referral: Just prior to the initial scheduled appointment was changed from an MCO to another MCO. The appointment had to be canceled because MCO would not authorize the appointment as the patient had not established with a MCO PCP yet. The patient searched and found a new PCP with MCO and was seen. After seeing the new PCP the patient needed a referral to Gastroenterology or Hepatology and then could be referred and authorized for a Liver Transplant Evaluation thru MCO. This caused a 6 week delay for the patient.
- New Liver Transplant referral: Patient was insured with a Medicare Advantage plan (an HMO) and new to a now, CCO. He had established with a PCP with the Medicare plan and the transplant referral was authorized, but the patients secondary insurance CCO and his Medicare HMO PCP were not on the CCO's list of PCP's. MCO told the patient he had to establish with the CCO. The CCO helped the patient select a PCP and he scheduled the appointment. This is not right no one should have two PCP's that is fragmented care in the worst sense and contrary to the intent of the CCO program. The CCO solution was to negotiate a CCO contract with the patients current PCP and after a couple more weeks the contract was signed. His referral was finally authorized and scheduled. The patient was delayed the care he needed by 4 weeks.

- Patient on the Heart Transplant waitlist, with CCO and as required needed regular dental care to stay active on the waitlist. The patient could not access timely dental care even with the help of family and her social worker. She could not get a future appointment with a dentist. The patient found a dentist that promised to help her very quickly if she got into another CCO. She was able to convince her eligibility worker to change the plan

from one CCO to another which would occur the 1st of the next calendar month. The patient transplanted before the end of the month. The hospital course spanned from the end of one calendar month into the next when there was much confusion from both plans about prior authorizations required for the post transplant care and prescriptions for her hospital discharge. With intervention she was allowed to stay on her current CCO and no lapses in coverage occurred.

- Many of these problems stem from the fact these issues are contractual and not clinical in nature, so there is not enough attention placed on the unforeseen impact of barriers caused by these contractual issues and the stress this places on the patient and the overall detriment this causes to the health of this individual.

- These problems do not fix themselves. They take several calls between multiple agencies and people like me to fix. Examples like these happen each and every day. Please take time to construct sound policies and procedures to maintain good Primary Care Continuity.