

Oregon Health Network

Sustainability Plan

October 27, 2008

Organizational Structure and Participation Fees

Oregon Health Network (OHN) is an Oregon non-profit corporation incorporated and organized as a public benefit corporation. OHN participants pay participation fees to OHN in order to connect to the network and receive the benefits of their participation, including, but not limited to, access to the Rural Health Care Pilot Program (RHCPP) subsidy funding. After the RHCPP is completed, OHN will continue to assist eligible rural participants with applications for funding from the regular rural health care program of the Universal Service fund and to assist participants with telehealth applications support.

Initial participation fees were set at a level sufficient, in the aggregate, to pay for both OHN administrative costs and any continuing costs of network common elements, such as the Network Operations Center (NOC) and access to Internet2/National Lambda Rail, that are not paid directly by network participants or their network access vendors. The value of the NOC to OHN participants is in the quality of service and network monitoring capabilities the NOC makes possible. The OHN NOC will make it possible for hospitals, clinics and community college allied health programs to use real-time telehealth applications that would be not sufficiently reliable over the open public Internet.

Larger urban hospital systems have agreed to pay substantially higher participation fees than smaller hospitals and clinics because the larger systems will benefit from the provision of telehealth services to smaller hospitals and rural clinics and from the referral of patients to their hospital systems. Federally Qualified Health Centers and small rural clinics will pay a nominal fee (currently set at \$200 per year). The Oregon Department of Community College Workforce Development (CCWD) has agreed to pay the participation fees for the 17 Oregon community colleges that will be connected to OHN. A majority of the OHN board of directors consists of representatives of the hospitals, clinics and community colleges participating in OHN. That board is responsible for setting participation fees at a level sufficient to keep the organization sustainable.

A copy of the Oregon Health Network fee structure document, which was approved by the OHN board of directors at their September 19, 2008 board meeting, is shown in Appendix 1. The board is responsible for adjusting fees and expense commitments in a manner that maintains sustainability. As noted in the fee structure document, the fees are scaled so that larger institutions (with higher annual revenues) pay larger fees in order to subsidize smaller and more rural entities. Table 1 shows the formula for hospital fees. This results in fees ranging from \$200

per year for Oregon's smallest rural hospital to \$29,000 for Oregon's largest (mostly urban) multi-hospital system.

As table 2 indicates, Oregon's 17 community colleges have a shared collective fee of \$150,000 per year, currently being paid by the Oregon Department of Community Colleges and Workforce Development (CCWD). Table 3 shows the fees for hospitals and health systems. Table 4 shows a scaled four-tier fee structure for pharmacies, clinics and other health-related organizations ranging from \$1,000 to \$10,000 per year based on total revenues. A major exception is the flat annual rate of \$200 per year for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

OHN is also establishing an Industry Council with fees ranging from \$1,000 to \$10,000 per year based on annual revenues. (See Table 5.) Health insurers are also invited to join OHN, and pay fees ranging from \$30,000 per year for Oregon's largest insurer to \$1,000 per year for the smallest insurer. The fee scale for insurers is based on the number of lives insured in Oregon, rather than total revenue. (See Table 6.) OHN understands that for-profit organizations, including insurers and pharmacies, among others, are not eligible for FCC subsidy funds. Nevertheless some for-profit health-related organizations are interested in participating in OHN, contributing to its sustainability and obtaining the benefits of interconnection with OHN.

The fee structure was constructed in such a way that all of the minimum expenses of OHN will be covered from the fees paid by the half dozen largest hospitals in Oregon plus the community colleges. Revenues in excess of that may be used to expand the services provided by OHN, particularly in the area of applications support. Applications support will be important in the period after the RHCPP because the applications running on the network are the major reasons for continuing network participation.

Each OHN participant will be asked to enter into an OHN participation agreement that includes a statement of intention to continue to participate in OHN and to continue to pay the unsubsidized portion of their telecommunications connections to OHN after the conclusion of the RHCPP. They will not be in a position to make binding legal commitments for expenditures more than five years in advance, because too much can change in that time period. However, they will be asked to make a commitment of intention to continue to participate, absent compelling changes in their financial condition or in the availability of USF subsidy funds.

Telecommunications Costs

Each OHN participant will be the customer of record with the telecommunications carrier providing the transport connection from their location to specified OHN exchange locations. The costs of interconnecting OHN participants at the NorthWest Access Exchange (NWAX), which is the primary OHN interconnection location, and other regional exchanges are included in the fees each participant will pay to the network vendors that connect them to those exchanges. During the RHCPP all participants will pay the 15% co-payments for recurring service charges

from telecommunications vendors for services to their facilities. Hospitals based in urban locations will pay all of their 15% co-payments for both recurring and non-recurring charges. (Non-recurring charges for urban institutions are not expected to be large because it is unlikely that new telecommunications facilities will need to be constructed to connect their locations.)

All participants understand that after the RHCPP they will be responsible for paying 100% of the network charges to connect them to OHN. As noted above, each OHN participant will be the customer of the telecommunications vendor providing services to their location and will be responsible for paying the unsubsidized portion of recurring charges. Much of the RHCPP subsidy will be for one-time construction and installation charges for getting broadband facilities to the premises of OHN participants and the communities in which they are located. Once initial construction is completed, OHN anticipates that the monthly recurring charges at the end of the RHCPP will be affordable to participants.

Rural participants eligible to participate in the regular rural health care program of the Universal Service Fund (USF) expect to obtain some subsidy from that fund when the costs of telecommunications services to their eligible rural sites substantially exceed comparable costs to serve urban locations. However, they understand that the regular program may be changed and that there are no guarantees concerning how it will operate at the end of the RHCPP.

The continuing benefits for urban hospitals to financially support OHN after the RHCPP include the ability to provide medical services to and receive patient referrals from the rural sites on the network. The advantages to them do not depend on a subsidy for telecommunications services.

For rural participants, the opportunity to receive telecommunications subsidies from the regular USAC rural health care subsidy program will be an important factor permitting sustainability. Oregon is a very rural state that includes many sparsely populated “frontier” counties. At least one Oregon health facility is not applying for the 85% RHCPP subsidy, because their subsidy under the regular program is more than 85%. Most rural sites in Oregon that are eligible for subsidy under the regular USF rural health care program have not done so because of the cumbersome administrative process required to obtain the subsidy. Most rural clinics do not have staff with the skills and the time to work the process. Oregon has been much more successful in receiving funds from the USF schools and libraries (“E-rate”) program because Oregon had established centralized staffing in the state government to assist schools with the administrative processes necessary to obtain the funding. After the RHCPP, OHN will provide that centralized support for eligible rural health sites.

OHN participants will sign a “participation agreement” in which they state their intention to continue participation in OHN after the RHCPP is over. However, non-profit organizations, particularly those dependent on federal or state government funding, as most are,

will not be able to enter into binding contractual commitments of funding for periods more than five years into the future.

OHN is structured so that participating entities are the customers of record with the telecommunications providers and so that what is being obtained from the telecommunications providers is leased capacity from their sites to the OHN exchange location. This arrangement should make it easy to transition from the RHCPP to the regular program that pays the difference between urban and rural rates for comparable service. Even though Internet services are provided over the leased capacity, this arrangement is necessary to ensure that rural participants are eligible for the full difference between urban and rural rates, not just the subsidy for Internet services that is capped at 25 percent. OHN anticipates that the services to be obtained under the regular program after the RHCPP will be procured under a new round of competitive bidding with the condition that service providers bidding must be providers eligible to receive the standard rural subsidy of the difference between rural and urban rates and not be limited by the 25% subsidy limit for Internet-only services. The network connections being leased under the RHCPP are all services with guaranteed capacity and network quality of service from the user premises location to a designated OHN exchange location. Therefore, OHN anticipates that the same vendors will be eligible to provide subsidized services under the regular USF program without the 25% limit that applies to Internet-only services, provided that their service renewal options under the RHCPP subsidy program or a new lower bid price is the most cost-effective solution provided in a new round of competitive bidding.

One Time vs. Recurring Network Charges

Much of the OHN RHCPP subsidy funding will be used for the one-time charges (construction and installation fees) necessary to construct broadband facilities to reach rural locations that currently lack adequate broadband facilities. Once the telecommunications vendors have installed facilities needed to serve those communities, the recurring charges are expected to be affordable for most hospitals, clinics and colleges. For rural locations with recurring charges substantially higher than those in urban locations, OHN will assist in identifying and applying for subsidies from the regular USF rural health care program, if it is still available, and/or from other government and charitable foundation sources. As noted above, OHN participants do understand that they are ultimately responsible for paying for the telecommunications connections needed to reach their facilities. The fact that they will be the customers of record with the telecommunications vendor serving them and are responsible for recurring cost co-payments during the RHCPP subsidy period underlines that responsibility.

There may be some turnover of participants during and after the RHCPP, but the network design permits both the addition of new sites and withdrawal of other sites without any negative impact on the network as a whole. Each telecommunications link from a participant organization to an OHN exchange location is independent of other links.

Network Infrastructure Ownership

OHN will be using telecommunications services from telephone companies and other network providers, not taking title to physical assets such as fiber optic lines or switching equipment. Therefore, the Oregon network facilities made possible by the RHCPP subsidy will continue to be available after the pilot program period. OHN will require that vendors of network access and transport services include in their service contracts long term renewal options at guaranteed prices in order to ensure that OHN members continue to get the benefits of any RHCPP program subsidies for construction and installation charges. However, because telecommunications is a cost declining industry and because competitive bidding will be required to obtain subsidies from the regular USF rural health care program, participants are not expected to enter into vendor contracts of more than five years. Having a guaranteed renewal price in the original contracts will provide a guarantee of continued availability of service in the unlikely event that future competitive bidding processes do not result in lower prices.

Rural health clinics are often financially marginal enterprises that endure a lot of closures and (hopefully) re-openings. If any particular OHN participant discontinues use at some time after the end of the subsidy period, the network facilities will continue to be owned by the telecommunications provider and available for them to use to serve other customers. This feature of the OHN plan is particularly important for the economic development of rural communities in Oregon and for the expansion of broadband services to other customers. By leaving ownership and operational control of telecommunications facilities in the hands of the telecommunications carriers themselves, rural communities will receive broader benefits from the expansion of broadband services made possible through the RHCPP.

OHN Budget

A budget projection for Oregon Health Network from inception through June 30, 2012 is shown in Appendix 2. Funds needed for the current Oregon legislative biennium ending June 30, 2009 have been received or have been contractually committed. Additional funds will be requested from the Oregon legislature when it convenes in January 2009 for the July 1, 2009 to June 30, 2011 biennium. Most of the state government funds under current contracts or planned for request from the 2009 legislature are for the 15% co-payment for one-time construction and installation charges for telecommunications services to reach health or health education institutions in currently unserved or underserved rural communities.

During the organizational phase of OHN, before it was incorporated and could open its own bank accounts, revenues were paid to and expenses were paid by the OHN fiscal agent, the Oregon Association of Hospitals Research and Education Foundation (OREF). The estimated budget for the fiscal year ending June 30, 2009 (shown in the first column of project projections) incorporates and includes all of the actual to date revenues and expenses shown in the actual

column plus projected revenues and expenses for the remainder of the fiscal year. That includes the reimbursement to OREF for expenses paid on behalf of OHN during the start-up period.

The projected revenues from participation fees shown in the projections are the minimum numbers needed to cover the estimated expenses and reach \$302,000 in the fiscal year ending June 30, 2012. This amount matches the projected operational cost subtotal for that year. Given the proposed fee schedules and anticipated number of OHN participants, there should be no difficulty in achieving revenues that exceed those costs.

In the fiscal years ending June 30, 2009 and 2010, the FCC subsidy for OHN and the 15% co-payments are shown in the two network cost lines. State government and private foundation sources are committed or anticipated to cover the 15% co-payments for non-recurring costs of network construction to reach rural sites. Those funds will flow through OHN. However, as noted above, some of the 15% co-payments will be paid directly to vendors by OHN participants. All of these matching funds from all sources are shown in this projection as if they came through OHN because OHN must certify the eligibility for subsidy and the fact of payment.

After June 30, 2010, when all FCC subsidy funds will be contractually committed, no network revenues or costs are shown in these projections because OHN participants will be paying those costs directly to network vendors. OHN hopes to negotiate contracts with the providers of network common elements, including the Network Operations Center, such that services provided after the RHCPP is completed will be billed directly to OHN participants or the telecommunications vendors that provide their OHN network access. Any network common elements that cannot be paid for in this manner will be paid by OHN directly to the providers of those common elements with costs recovered through OHN participation fees.

The OHN operational costs for fiscal years ending June 30, 2011 and 2012 will cover all costs associated with managing this program and its financial and other reporting requirements. OHN will continue in existence after the conclusion of the RHCPP to help its rural participants obtain subsidy funding from the regular USF rural health care program and other sources. It will continue to provide applications support and technical consultation services to OHN participants and engage in other program development activities to advance telehealth applications in Oregon.

Appendix 1

Oregon Health Network Fee Structure

I. Methods & Approaches to Setting Fees

“Top Down” is a commonly used model for setting fee structures. In the Top Down model, administrative and operating costs are projected. Categories of membership/ participant groups are identified. A fee scale is then established for each category or group. The study estimates the number of participants anticipated per category over a twenty-four month cycle. Estimates per category are summed to determine total anticipated revenues. The anticipated revenues from fees are compared to projected administrative and operating costs. When membership fees are equal to or greater than the administrative and operating costs the final step is taken. The last step reviews the membership fees for believability. Are these fees attainable? If yes, the study is complete and the project can move forward. If membership fees do not cover administrative costs, alternate models must be explored.

The OHN fee structure proposed herein uses a modified Top Down approach. Administrative and operating costs were established for a five-year period. Five categories of users were created (hospitals, community hospitals, other health organizations, industry council members and payers). Because the largest core users of the OHN during the first years of operation will be hospitals and community colleges, a fee structure was built that would achieve sustainability by fees from those two categories alone. It is not reasonable to assume that the OHN will achieve 100% participation of these two groups (if at all) until year four. Therefore, it is projected that OHN administrative and operating costs during the first three years of operation will be supported by a blend of fees and one-time donations. Full OHN sustainability through participant fees is projected to be achieved by year four (and ongoing), in conformance with one of the following scenarios (or any number of permutations in between): 1) if 100% of the hospitals and community colleges (as the core large users of the OHN network) agree to participate and pay

their proposed fees; or 2) if the largest one-third of hospitals and community college systems participate; and, in addition, 3-5 of the largest prospective participants from other health aligned systems, payers or industry council participants elect to participate and pay their proposed fees. Over a five-year timeline, we anticipate that OHN Administration and Operations will cost approximately \$1,200,000, of which approximately \$950,000 will be derived from fees and \$250,000 will be derived from donations.

II. Fee Structures

ASSUMPTIONS: The OHN fee structure was developed to be consistent with the dues system that that hospitals are familiar with through their participation in the Oregon Association of Hospitals and Health systems (OAHHS). The levels and revenue ranges for the hospital fee structure are presented on Table 1 below.

Table 1

OREGON HEALTH NETWORK FEE STRUCTURE			
	Revenue Range		
Level	Minimum (000)	Maximum (000)	Rate
Four	\$100,000	and over	0.0148
Three	\$40,000	\$99,999	0.0246
Two	\$20,000	\$39,999	0.0369
One*	\$0	\$19,999	0.0492

*The lowest fee for hospitals is \$200. All FQHCs and RHCs will be assessed a fee at this lowest level.

The same 4 levels and ranges used by the OAHHS (Table I above), have been adopted for the four categories of OHN participants as follows: 1) hospitals (Table 3 below); 2) other health related organizations (Table 4 below); 3) industry council participants (Table 5 below); and payers (Table 6 below). The fees for levels one, two and three for the categories of other health organizations, industry council members and payers are consistent with the highest hospital fee in each of those levels (\$1000, \$1800, and \$3500 respectively). While the hospitals and payers' range extends to a high of \$30,000, the other health organizations and industry council members has been capped at \$10,000 in that their "value added" is less than for hospitals and payers. Fees for hospitals, other health organizations, and industry council participants are based on gross revenues (in Oregon). The payers' assessed fees are based number of lives insured in Oregon, using ranges that are similar to the hospital ranges. Organizations that fall outside of the four

categories (e.g. non revenue producing companies, self-insured groups, Public Health entities, etc.) will be decided on a case-by-case basis, and every effort will be made to be fair and consistent with the established fee structure. Community Colleges have elected to participate as a group and have been assessed a lump fee, which is currently being supported by CCWD (fees may be assumed by individual colleges at some time in the future). That group fee is presented in Table 2 below.

Table 2: Community Colleges

Community Colleges/Collective	150,000
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Table 3: Hospitals

OREGON HEALTH NETWORK HOSPITAL FEE STRUCTURE				
	Revenue Range	Revenue Range		Fees
Level	Minimum (000)	Maximum (000)	Rate	
Four	\$100,000	and over	0.0148	
Three	\$40,000	\$99,999	0.0246	
Two	\$20,000	\$39,999	0.0369	
One	\$0	\$19,999	0.0492	
Hospital Organization				Total Fees
Providence Health System (7)				Level Four
Legacy Health System (4)				Level Four
OHSU Hospital				Level Four
PeaceHealth (2)				Level Four
Samaritan Health Services (5)				Level Four
Pacific Health Horizons (2)				Level Four
Asante Health System (2)				Level Four
Cascade Healthcare Community (2) <i>(including Pioneer Memorial Hospital)</i>				Level Four
Kaiser Permanente				Level Four

Adventist Health System (2)				Level Four
Sky Lakes Medical Center				Level Four
Mercy Medical Center				Level Four
Tuality Healthcare				Level Four
Bay Area Hospital				Level Three
McKenzie-Willamette Medical Center				Level Three
Willamette Falls Hospital				Level Three
Willamette Valley Medical Center				Level Three
Mid-Columbia Medical Center				Level Three
Silverton Hospital				Level Three
Holy Rosary Medical Center				Level Three
Good Shepherd Medical Center				Level Three
Columbia Memorial Hospital				Level Three
Ashland Community Hospital				Level Three
St. Anthony Hospital				Level Two
Grande Ronde Hospital				Level Two
St. Elizabeth Health Services				Level Two
Santiam Memorial Hospital				Level Two
Mountain View Hospital				Level One
Lower Umpqua Hospital				Level One
Curry General Hospital				Level One
Bluc Mountain Hospital				Level One
Southern Coos General Hospital				Level One
Lake District Hospital				Level One
Wallowa Memorial Hospital				Level One
Harney District Hospital				Level One

Coquille Valley Hospital				Level One
Pioneer Memorial Hospital (Heppner)				Level One
Total Hospital Fees				167,300

Table 4: Health Related Organizations

Level	Revenue Range	Revenue Range	Fees
	Minimum (000)	Maximum (000)	
Four	100,000	And over	\$10,000
Three	40,000	99,999	\$3,500
Two	20,000	39,999	\$1,800
One	0	19,999	\$1,000

(FQHCs and RHCs will be assessed a standard fee of \$200)

Table 5: Industry Council Participants

Level	Revenue Range	Revenue Range	Fees
	Minimum (000)	Maximum (000)	
Four	100,000	And over	\$10,000
Three	40,000	99,999	\$3,500
Two	20,000	39,999	\$1,800
One	0	19,999	\$1,000

Table 6: Health Plan Payers

Range in Number of Lives Insured	Fees
100,000 and over	\$30,000

40,000-99,999	\$3,500
20,000-39,999	\$1,800
19,999 and under	\$1,000

Appendix 2

Oregon Health Network Budget Projections
 Projected Program Report of Revenue, Expenses and Uses of Funds
 December 1, 2007 through June 30, 2012

		Project Projections (g)				
		Estimated	Estimated	Estimated	Estimated	Estimated
		FYE	FYE	FYE	FYE	Total
		FYE 6/30/2009	06/30/2010	06/30/2011	06/30/2012	
Revenue:						
<i>Source:</i>	<i>Purpose:</i>					
FCC (a)	RHCPP (f) 85% Subsidy	\$ 13,455,083	\$ 6,727,542	\$ -	\$ -	\$ 20,182,625
OECD (b) Strategic Reserve Fund	RHCPP (f) 15% Match	500,000		-	-	500,000
CCWD (c) (Blue Mt Comm. College)	RHCPP (f) 15% Match	100,000		-	-	100,000
CCWD (c) (Blue Mt Comm. College)	RHCPP (f) 15% Match	250,000	250,000	-	-	500,000
ODE (d)	RHCPP (f) 15% Match	750,000		-	-	750,000
DAS (e) or ODE (d)	RHCPP (f) 15% Match	750,000		-	-	750,000
M J Murdock Foundation	RHCPP (f) 15% Match	500,000		-	-	500,000
CCWD (c) (Blue Mt Comm. College)	Administrative	200,000		-	-	200,000
Participation Fees	RHCPP (f) 15% Match/Admin.	140,000	218,000	290,000	302,000	950,000
Private Foundations/Donations	RHCPP (f) 15% Match/Admin.	70,000	445,000	-	-	515,000
Total Revenue		\$ 16,715,083	\$ 7,640,542	\$ 290,000	\$ 302,000	\$ 24,947,625
Expenses:						
<u>Network Costs:</u>						
RHCPP (f) Network Costs	85%	\$ 13,455,083	\$ 6,727,542	\$ -	\$ -	\$ 20,182,625
RHCPP (f) Network Costs	15%	2,374,426	1,187,214	-	-	3,561,640
Subtotal Network Costs		\$ 15,829,509	\$ 7,914,756	\$ -	\$ -	\$ 23,744,265
<u>Operational Costs:</u>						
Executive Director		171,300	151,400	156,700	162,200	641,600
Associate Project Coordinator		85,345	72,200	74,800	77,400	309,745
Other Operating Expenses		58,715	30,400	34,500	38,400	162,015
Administrative/Fiscal Services		18,000	24,000	24,000	24,000	90,000
Subtotal Operational Costs		\$ 333,360	\$ 278,000	\$ 290,000	\$ 302,000	\$ 1,203,360
Total Expenses		\$ 16,162,869	\$ 8,192,756	\$ 290,000	\$ 302,000	\$ 24,947,625
Program Revenues over Expenses		\$ 552,214	\$ (552,214)	\$ -	\$ -	\$ -

Acronyms:

- (a) FCC Federal Communications Commission
- (b) OECD Oregon Economic & Community Development Dept.
- (c) CCWD Community Colleges Workforce Development
- (d) ODE Oregon Department of Education
- (e) DAS Department of Administrative Services
- (f) RHCPP Rural Health Care Pilot Program
- (g) Projected budget and subject to change

Projected Funding Status:

Secured	\$ 21,302,625
Pending Approval	1,250,000
Anticipated Participants	950,000
Anticipated but Not Formally Requested	1,445,000
Total	\$ 24,947,625