

Interview with Barney Speight

In June 2007, Oregon lawmakers enacted, and Gov. Ted Kulongoski signed into law, SB 329, the Healthy Oregon Act. SB 329 calls for a broad reform of healthcare finance and delivery systems, aimed at reducing the number of Oregonians without health insurance and ensuring access to affordable care, primarily by expanding public health coverage.

The new law created the Oregon Health Fund Board (OHFB) to study and recommend the elements of a comprehensive reform plan. The seven-member board, appointed by the governor and approved by the Senate, is charged with presenting its recommendations to the legislature by October 1, 2008.

OHFB executive director Barney Speight's career in health care spans nearly three decades. Most recently, he served as deputy administrator of the Washington Health Care Authority for 2 years. Before that, he worked for 25 years in Oregon in leadership positions with public and private organizations, including as administrator of the Office of Medical Assistance Programs, overseeing the state Medicaid program, and as administrator of the Office for Oregon Health Policy and Research (OHPR).

Acumentra Health senior writer Greg Martin sat down with Mr. Speight in January 2008 to talk about healthcare reform issues and the board's progress in meeting its legislative mandate.

- 1. The OHFB has a weighty task—to create a comprehensive health reform plan for Oregon. First, please tell us about the background and experience of your board members and staff and what they bring to the table.*

The governor wanted to make sure that the board had a very strong voice and perspective of the purchaser community and of representatives of consumers of healthcare services. Bill Thorndike [president of Medford Fabrication], who chairs the board, is a third-generation board member of Asante in Medford. Bill has been involved over the last decade-plus in a lot of policy issues, bringing the perspective of the business community—he's been a leader in the Oregon Business Council and Associated Oregon Industries, and has been involved in K-12 reform and higher education reform. He has the perspective of governance of health care and brings a strong private purchaser's perspective. Eileen Brady, one of our vice-chairs, is co-founder and co-owner of New Seasons Market and is on the board of a small public relations firm. She would characterize herself as looking at health care from a purchasing point of view, both as a relatively large employer—New Seasons has 1,800 employees, and they started on Day 1 providing health insurance to their employees—and also from the perspective of purchasing and maintaining health insurance for a small service organization. Jonathan Ater, the other vice-chair, is an attorney and principal of Ater Wynne in Portland. Jonathan serves on the Oregon Health Policy Commission and was involved in all the work the commission did in developing its “road map” for reform, which was finalized in July 2007. That road map is serving as a framework or point of departure for a lot of the work of the board and its committees. [Other board members include Charles Hofmann, MD, an internal medicine specialist in Baker City; Tom Chamberlain, president of the Oregon AFL-

CIO; Ray Miao, president of the Oregon Chapter of AARP; and Marcus Mundy, president of the Urban League of Portland.]

The chair of each committee that the board creates is an ex-officio member of the board. Those ex-officio members are where we bring in much of the expertise on finance and delivery. We have six committees [studying finance, the delivery system, benefits, eligibility and enrollment, health equities, and federal laws], so in effect, we have a working group of about 13 people. As someone characterized the board when it was first named, they're not the "usual suspects"—they bring an interesting diversity of experiences and perspectives. [In addition to the small OHFB staff, professional staff from the OHP, Health Services Commission (HSC), and Medicaid Advisory Committee work with "Team 329."]

It is a herculean task to be handed a charter like SB 329 with about 14 months—now more like 10—and a little over a million dollars to develop a comprehensive plan. I envision that we will deliver a report with a series of recommendations. The legislation provides that the board can go the Legislative Council and have bills drafted at our request, so that if the board deems that proposed legislation is appropriate to forward the recommendations, we'll have that drafted. The combination of the written report, its recommendations, and any attendant proposed legislation will, in some part at least, frame a portion of the healthcare agenda for 2009. And then the game starts all over again.

2. *What are the dimensions of the problem that the OHFB was created to address?*

Those of us who have been in health care find ourselves in 2007–2008 kind of where we found ourselves in 1988–1989, when I got involved in development of the Oregon Health Plan (OHP). Costs are escalating at what I believe are an unsustainable rate. The extent of employer-based coverage is shrinking, in large part because of the cost issue. Nationally and to some degree here, there is a possibility of getting better value out of the dollars we're spending relative to quality, coordination, and safety. But I think the overriding issue is that almost 600,000 Oregonians, or 16 percent of the population, are without coverage. That puts us literally back where we were back in the late 1980s, when then-Senator John Kitzhaber and a whole bunch of people began addressing the issues of cost and access.

There is a social/moral issue around the uninsured. There's also a greater understanding now than I've ever seen among some segments of the business community of the cost issues that are associated with funding care implicitly through a cost shift—as opposed to explicitly, in which case we could at least manage the costs and know how much they are.¹ With the convergence of all those factors, health care is returning as a top-of-mind issue, not unlike what it was in the late 1980s and early 1990s. This is the third time in my professional career that we're at one of those moments when as a society, we look into the mirror and decide what we're going to do for the next 10 years, if anything.

3. *How would you characterize the 600,000 uninsured Oregonians?*

¹ The "cost shift" refers to offsetting the unpaid costs of care delivered to one patient population by collecting higher payments from other patient populations. For example, when a hospital provides services for an uninsured person who cannot pay, the hospital typically covers those costs by increasing the amount charged to private payers for health services. Similarly, hospitals recover shortfalls in payment under public programs through additional increases in payments by private payers. Much of the cost of uncompensated or undercompensated care is shifted to the privately insured, including employer health plans.

About 20 percent are kids under age 19. With regard to family incomes, a market analysis of the uninsured would show three broad groups. First, about 30 percent have incomes at or below 100 percent of poverty, and a good share of those are adults. The OHP—and particularly the expansion of the plan, now known as OHP Standard—was designed to serve those people, but with the dot-com bust in 2000 and the fiscal exigencies of the state, that program has shrunk from a high of about 125,000 down to about 20,000 now. *[Editor's note: In March, the OHP will begin accepting new enrollees for the first time in more than three years. The state will use a lottery system to enroll 2,000 eligible applicants per month for 11 months, raising the total enrollment to 32,000.]* About one-quarter of the uninsured have incomes from 300 percent of poverty on up. One would assume that they generally should have enough discretionary income to at least buy some form of catastrophic coverage. And then you have the folks I call the “tweeners,” somewhere between 100 and 300 percent of poverty, who are in working families. Many of them work for employers that don’t provide coverage; some work for employers that provide coverage, but they’re not eligible because they may work part-time or may be in a 90-day or 6-month probationary period, and many have multiple part-time jobs. They’re not in poverty per se, but they’re not middle class either. In essence, we’re trying to think through different strategies for those different groups.

4. *What are some of your design principles and assumptions?*

We will build on some of the foundational elements that are already present. The framework of SB 329 has some implied premises. One operating assumption is that a good share of Oregonians, if not a majority, will continue to get their health care through employer-based coverage. Another is that we have almost 15 years of experience with the OHP in how to use managed Medicaid—in many ways, the last vestige of prepaid capitated, risk-based, evidence-based healthcare finance and delivery—and some modest experience with premium assistance programs like the Family Healthcare Insurance Assistance (FHIA) program, and we will look at those models. Then we’ll look at reform in other states, like the Massachusetts model or what California is considering. They’re looking at ways to both expand coverage for the poor—that gives us the advantage of a federal match, as long as we can get the necessary waivers—and probably some form of premium assistance for the “tweeners” who can’t afford the full cost of a premium, whether it be through a public or a private delivery system.

The board will look at an individual mandate for affordable coverage—and to make it affordable, you need some sort of funding stream for premium assistance to meet the needs of those who can’t afford it on their own. Some people up the income level would be required to buy some form of coverage with their own resources. For those at 300 percent of poverty or above, I don’t think there should be a huge intervention policy-wise as to the kind of coverage they buy. The real issue is particularly among those folks called the “young immortals,” who simply don’t think they’ll ever get sick or that they’ll need health care—but if they have a catastrophic event, often they can’t cover it—to get them into some sort of pool.

One principle of SB 329 is the concept of shared responsibility, and that also applies to employers that don’t provide coverage. With ERISA [the Employee Retirement Income Security Act of 1974], no state can tell an employer to provide coverage, but we believe—as Massachusetts demonstrated, and as California is trying to do—that in the absence of

coverage, an employer should pay something, on some basis, into some fund to help working folks who don't have employer-based coverage.

5. *So by one mechanism or another, the goal would be to achieve universal coverage.*

As near as we can. When I was working with Gov. Kitzhaber, I said if we could get the uninsurance rate down to 5 percent, I would declare victory and go home. There will always be some people who don't fit into any kind of program. But if we had a stable and somewhat diversified funding mechanism, we could expand the OHP relatively quickly.

Maybe a staged approach will work. I envision that some of our recommendations could be adopted in 2009 or 2010, and some others may be longer-term. We don't believe that there's a single "silver bullet." In Oregon, any new revenue source is probably subject to a ballot challenge, through either referral by the legislature or an initiative. Some of the undertakings that the board feels very strongly about in the area of reforming the delivery system have a time horizon of three, five, seven years. The healthcare finance and delivery system is complex, and you know the old metaphor about turning the *Queen Mary*.

6. *Currently, Oregon covers about 360,000 people on Medicaid, and we spend about \$4 billion per biennium in state and federal money to provide health coverage for them. Now we're talking about bringing a substantial number of additional people into public coverage. How much will that cost?*

The Health Policy Commission estimated that to insure all or nearly all of the folks who are now uninsured—understanding that some wouldn't have any public subsidy at all—would cost about \$550 million per year in new state spending. That would mean roughly a two-thirds increase in state spending for health coverage.

7. *Considering the cost of expansion, how feasible is it to bring in all the uninsured?*

I think a lot of Oregonians would say that \$550 million a year is a lot of money, and it is. But consider that the total annual healthcare expenditure in Oregon is estimated at \$18 billion a year. If you take out Medicare, VA, and Medicaid, private healthcare expenditures are in the range of \$8 billion, and in that \$8 billion are the implicit costs that are already subject to the cost shift. If you think of that \$600 million in light of total expenditures, and if you think of a way that we could at least monitor what I call the recapture of the cost shift, it becomes a less awesome number. But whatever the revenue strategy is, whether it's some sort of surcharge on the personal income tax, or a payroll tax on the employee or employer, or both—we're also looking at a health transaction tax like what Minnesota has for physicians, hospitals, and pharmaceuticals—all of those are controversial. Our revenue committee wants to look at a tobacco tax and other "sin" taxes. But whatever we recommend, it should be very broad-based and equitable, and should ultimately be seen by those who pay it as a solution around this implied cost shift. To some degree, building a consensus around that is going to be tough.

Some in the business community will say, "No, never," and others will say, "Well, I'm already paying for it now—what I want to know is, what's the framework of the world that we're going to work in, and after we get a good share of these people covered, am I going to see the year-over-year increases in my premium go down?" We're not going to stop premium increases, but if we can at least "bend the curve"—that is, change the cost curve by 1.5 to 2 percent over a 10-year period—that's a huge savings. I think we're never going to get the

cost increases down to the CPI [Consumer Price Index] for a lot of reasons, particularly technology, but I do have abiding hope that we can put a system in place where instead of having 8, 9, 10 percent increases above the CPI, we'd have 5, 6, 7 percent increases and be sustainable. Part of the problem with the underwriting curve is that we get it down to 4 percent one year and then it's 15 percent three years later. It's those shocks that small businesses in particular can't take—they need predictability.

8. *Do you anticipate that the board will recommend a single financing mechanism or else a range of options?*

I suspect that there may be multiple financing recommendations—in part because strategically, we need to have diversified funding mechanisms. For example, a health transaction tax that could be used to go get a federal match to get folks into an expanded OHP and then a payroll tax that would help fund those workers who don't get health coverage through their employers—these would have diversity in funding but also would be targeted to the populations to be served. But we'll see.

9. *SB 329 refers to the need to restructure “misaligned financial incentives” and the “inefficient” delivery system. Could you define those problems more specifically?*

The current, primarily fee-for-service-driven system has some perverse incentives. There are lots of questions being asked about how we get better value. The board has held a couple of hearings on the issue of revitalizing primary care and the concept of the medical home, particularly for managing multiple chronic diseases or co-morbidities. There's an emerging body of data, both in Oregon as well as nationally and internationally, that intense and aggressive primary care by multidisciplinary teams can improve continuity of care and improve self-management and care compliance—and also can save money because of coordination. But it's hard to get that to happen unless the payment system encourages that, incents it, and actually rewards it. Some providers would like to organize to be able to do that, but they find that the business model they're trapped in doesn't necessarily allow that to happen. There's a growing number of purchasers, both public and private, that buy into that model conceptually and say, “I'd be willing to pay for a model like that,” but we haven't got programs in place yet through third-party payers that can actually begin to transform the delivery system.

I think the board feels very strongly that a transformation of the delivery system can only come about if two underlying factors happen simultaneously. One, we need to find new models of how we pay for care, particularly for complex patients in ambulatory care, so that we pay for episodes of care around a particular illness, as opposed to just paying for a series of lab tests, office visits, etc.—what I call “creating widgets.” The other thing we're emphasizing is the issue of quality improvement and measurement. You know the old saw, “You can't manage what you don't measure.” The two fundamental strategies that the board is studying are: How do we develop a more robust system of capturing information about clinical performance, about financial effectiveness, about compliance with evidence-based standards, and use that to let providers know how they can improve? And then, how do we transform the delivery system to reward those who are innovating to meet or exceed those benchmarks? Those benchmarks should change over time. Under the concept of continuous quality improvement, we find new ones—we've hit the goal, and that one's taken care of, it's institutionalized and embedded in the delivery system, and what next can we do?

[We need] a delivery system that rewards both individual providers and provider organizations to innovate clinically to find new ways to deliver health care and be rewarded for that—whereas now, with many utilization and practice improvement approaches, the provider may actually lose money. The medical home concept envisions a number of outreach and clinical management approaches—email, telephone outreach calls, etc.—but if those aren't paid for in some way and the office visit is averted, in today's world, that provider actually reduces his or her income but conceivably improves the clinical outcome.

Ultimately, these issues are a challenge to public and private purchasers—first, to have patience, because some of this is going to take time, but also we're going to have to invest in some demonstration projects to confirm what intuition and other data tell us. Beyond the medical home, other kinds of payment reforms might need some trials of how to do them effectively. I think the third-party payer community has a big challenge here. I also think there are two fundamental camps in the provider community. Many are eager to do this kind of thing, particularly in primary care or in middle-size and large multidisciplinary clinics, but others in the provider community may not be particularly interested in it.

If we really had aggressive ambulatory diabetic care, ultimately we'd have fewer amputations, fewer ER visits, fewer admissions for medical complications. It's a "pay me now or pay me later" issue—the assumption is that the aggregate cost of paying me now will be offset by a lot of avoided costs in the future. Some are skeptical about that. I describe myself as a believer on faith in that model. It may not work in every clinical situation, but generally speaking, particularly in the management of chronic disease, I'm convinced that it does. A lot of health research points out that we built the system around acute care from the 1950s, and now 50 to 60 percent of what we spend is for chronic care in an ambulatory setting, or else in an acute setting that would be preventable if we had a more robust ambulatory delivery system.

10. What you've described so far applies across the country. In Oregon, are there features of our current healthcare system that are "working" and should be preserved? Are there specific challenges that are unique to Oregon?

Oregon is unique in the health policy arena, because we have a large enough population to have some major communities beyond Portland that have large, sophisticated, complex delivery systems, yet we're small enough that we can get the leadership of many Oregon organizations in delivery, finance, and government in the same room—whereas the California market is sort of a nation-state unto itself. The practice of medicine in Oregon has been quite different relative to the use of resources—we use hospitals more efficiently than a lot of places. We have a large prepaid practice with Kaiser Permanente, just as Seattle has Group Health, and I think those organizations have an important role to play in the system and offer an important laboratory for community medicine to learn from. We have a strong history of engagement with professional organizations like Acumentra Health in terms of quality review. We've learned a lot of lessons about managed care, particularly for the Medicaid population, with all the fully capitated health plans (FCHPs). I saw the expansion of managed care into the commercial sector in, I think, 34 to 36 counties, and then saw it retreat. I think there could be room for improvement in the Oregon Medicaid model, but it has spurred community-based organizations to work closely with doctors and hospitals in utilization review and quality improvement. That's a platform from which to learn.

As for Oregon-specific challenges, it seems much more difficult now to get people together to work on a consensus—there’s been a fracturing of community. It isn’t quite the same as it was 20 years ago. I’ve talked to a lot of people in just about every sector of healthcare delivery, finance, and purchase, and almost every one of them will say, either privately or publicly, that the status quo is not sustainable. But there’s a real difficulty in building a vision where we all give up something, but we’ll have a new opportunity, and we’ll adapt, and the greater good will be served. I don’t think there is a vision in which all the major players can see themselves in a new or modified role in a new system. Also, we’re all doing this in the middle of a huge national debate, so there’s a concern that whatever we may do in Oregon will get swept aside by whatever Washington, DC, does. But overall, there seems to be less flexibility for compromise.

11. Your board faces a deadline of February 1 to report to the legislature on your recommendations for designing and implementing a health insurance exchange. [Editor’s note: This insurance exchange for small employers and individuals would pool dollars from existing sources to leverage better rates from insurers and maximize federal funds. The state would manage the pool through existing managed care plans to control costs and set standards for essential health services.] Do you know enough about that now to tell us what you might recommend?

Our report will not describe an operating plan for the insurance exchange. We’ve learned that this issue is far too complex for us to develop an operating plan in 90 days. The insurance exchange is not a reform in and of itself—it’s a tool that sits inside a package of reforms. We’re working with a number of third-party payers and brokers to understand the issues. If we had an individual mandate, it would profoundly change the individual market from a voluntary to a mandatory market. What rules of the road would change because of that, how would that market be restructured, and in that new market, what would be the role of the exchange, particularly as an organization that could help administer premium subsidies? One of the difficulties of the FHIA is that it’s a fairly paper-intensive process. If you had an exchange with the carriers there and you had employer or individual dollars coming from payroll deductions and from subsidies, and the exchange brought all those together and routed them back to the carriers, it could be done relatively efficiently. We’ll put all this into a preliminary update of what we’ve learned.

12. As part of the comprehensive reform plan, how will you define the basic benefit package?

Our benefits committee has a tough job. I’ve been involved for over a decade in watching or participating with organizations that tried to define a basic or “core” benefit plan—SB 329 calls it an “essential” benefit plan. The Prioritized List for OHP has some value, particularly in the hierarchy of the broad categories that the HSC works with, but we have to consider a benefit framework that also would work in a commercial setting, and the Prioritized List hasn’t been used in that framework.

My argument has been—and not everyone agrees with me—that part of an essential or basic benefit package is not only what’s covered but how one pays for what has to be covered, and that varies based on the population you’re taking about. You can look at most commercial coverage and even at what’s covered on the Prioritized List now, and most medically necessary medical and surgical services are covered. Most of the services that are now “below the line” on the Prioritized List are things that would be excluded or subject to prior

authorization in a commercial setting. The committee will probably examine what services are being covered in the commercial setting compared with the Medicaid setting, and what things should be excluded. Clearly we'll try to emphasize coverage of services that use evidence-based approaches wherever possible, or limiting the coverage of a service where it's clearly known that the evidence doesn't support it use or that it's problematic. For populations where you can use incentives, we'd like to encourage the choice of evidence-based services by patients and providers.

I have a hard time envisioning a definition of essential benefits that doesn't cover medically necessary acute care, prevention, primary care, and ambulatory care. For some populations there might be limits—there are benefit designs that limit the number of office visits in a year. I have a hard time envisioning essential benefits not including pharmaceuticals, but with a recommendation for using evidence-based formularies and incentives for using generics where substitution is appropriate. And with mental health parity, I think it would be very unwise to exclude mental health services. Clearly, because of some socioeconomic and demographic issues, the poor suffer much more cruelly from mental health or addiction issues, and that is an underlying driver to healthcare problems.

13. *Your Federal Laws Committee is identifying the statutory and regulatory barriers to implementing the Oregon reform plan. Tell us about that committee's work.*

That committee has a charter to investigate where federal policy may get in the way of Oregon achieving the goals outlined in SB 329, particularly the goal of moving toward universal coverage. We'll have a series of invited testimonies around topical areas, starting with the Medicaid agency, since it has a major role in the federal partnership, to talk about how that partnership can be improved; and including the advocacy community, the health plan community, the FCHPs, and other contractors in the provider community. We'll do a similar effort with Medicare, and then look at other areas—the ones we know about now are ERISA and EMTALA [Emergency Medical Treatment and Active Labor Act] requirements. Some of the Oregon tribes would like for us to spend time looking at the Indian Health Service and at federal policy relative to American Indians and Alaska Natives at the state level.

14. *As you explore these federal barriers, which ones jump out at you as particularly challenging?*

From my experience, albeit brief, as Medicaid director for Oregon, I think the timing of decision-making with our federal partners is sometimes ludicrous. For example, the OHP waiver renewal was put in a year ago, and it wasn't until 30 or 45 days of the deadline that CMS [the Centers for Medicare & Medicaid Services] got into negotiations. The amount of time it takes to get a decision, particularly when you're seeking some flexibility around innovation, is frustrating. There's an awful lot of "Mother, may I?" and I understand that from a budget control point of view. Particularly with Medicaid, I would hope that we could work more collaboratively.

In the area of Medicare policy—not so much the Medicare Advantage plans, but for fee-for-service (FFS) Medicare—the fundamental framework for reimbursement is, I think, not only hurting Medicare beneficiaries in terms of access to physicians who will serve them, but potentially in cost shift for fee-for-service hospital and physician payment. Whatever hat I've worn over the past 15 or 20 years, it seems that Oregon has been penalized as a state that

historically has been more efficient than others on an adjusted average per-capita cost basis, and there hasn't been a recognition that maybe the cuts, or rather the smaller rates of increase, are more appropriate in some regions of the country than in others. I noted that one of the Commonwealth Fund's recommendations for national healthcare reform was that we need a more sophisticated look at special treatment for high-performing or efficient areas like Oregon, Minnesota, or Iowa that are trying to get greater value out of the Medicare program. On the other side of that, I understand that Oregon has 37 or 38 percent of its Medicare enrollees in Medicare Advantage plans, the highest enrollment in the country. I'm told that the reimbursement through Medicare Advantage plans is generally more acceptable to providers than Medicare FFS. So we're looking to see if we can develop a strategy for encouraging the creation of more or larger service areas, either by expanding the service areas of the current Medicare Advantage plans or by incenting the development of new Medicare Advantage plans in communities that don't have that choice now.

15. The board has to submit a progress report to the legislature by February 29. What will that report say about where you stand?

In 90 days, we've organized six committees, we've got almost a hundred citizens involved on a voluntary basis, we've recruited a staff, we've held 19 committee meetings, and we have 11 meetings scheduled for January and will probably have another 11 in February. I think we'll be well along the way with the committees working on their charters through some of the critical deliverables; some may be ready to work on recommendations during the March–April time frame—for example, proposals to create a state-level Quality Institute. We're moving forward on the comprehensive plan, and it will include recommendations as to how we expand access, how we ultimately can get costs more under control than they are, how we can improve quality and effectiveness. We hope that during the April–June time frame, the board will be able to craft a “straw person” set of recommendations. Then our intent is to take that out for comment at open public meetings, but also to major institutions, associations, and organizations asking for feedback.

In the case of some issues, we're into the tough discussion time. Let's take the exchange as an example. You could have an exchange with very broad powers that could act as a purchasing co-op, or a relatively passive exchange that just brings together insurers, and the products and prices are not particularly regulated or negotiated. As you begin to intertwine these issues, there's a bit of a problem in making sense out of it at the end. For example, part of what the benefits committee recommends may ultimately come back to some pragmatic decisions about how much money do we think we can convince Oregonians to pay—so benefit design becomes somewhat of a back-in to a number. The important thing for the benefits committee is to assign a hierarchy or priority to benefit issues, because we'll probably find that we won't have the finances to meet everybody's desires and even needs.

16. You've met with a number of community and stakeholder groups to discuss the board's activities. What feedback have you received about the public perception of the healthcare problem?

The feedback we're getting through our web page and our organizational email ranges widely. There's a very strong feeling among some folks who are very well organized to express an interest in a single-payer system. Others have very strong feelings about for-profit and commercial insurers. We've received expressions of concern about the growing numbers

of the uninsured and the social and health consequences of that, reaffirming that there's a human face to those 600,000 folks. As we go forward, we're going to try to use, within the budget and time available, various devices to listen to folks, as far as the problems they see and any proposed solutions they may have.

We should be finalizing our strategic communications plan in a few weeks. A big part of that is how do we organize ourselves in June, July, August, the early fall, and what are the tactical things that come into play. I think we're going to have to reach out to editorial boards, to public and community organizations, to the business community, because we want broad-based comment and feedback.

The opinions expressed in this interview are those of the interviewee and do not necessarily represent the opinions of Acumentra Health or its officers and employees.