Columbia Pacific CCO™ Jackson Care Connect™ CareOregon®

Pat Allen, Director
Oregon Health Authority
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Zeke Smith, Chair
Oregon Health Policy Board
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May 4, 2018

Dear Director Allen and Chair Smith:

I would like to thank you both for the multiple opportunities provided for public comment on the future of the coordinated care model, or, "CCO 2.0". The Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB) are well positioned to lead a thorough and thoughtful conversation on what has or has not worked within CCOs to chart the course for the next iteration of this innovative program; CareOregon is appreciative of the opportunity to engage in this conversation, and we look forward to working with the OHA and OHPB throughout the remainder of the CCO 2.0 process.

CareOregon is a 501(c)(3) nonprofit that has been offering Oregon Health Plan (OHP) services for almost twenty-five years. We currently support the administrative and/or risk management services for 4 Coordinated Care Organizations (CCOs) in Oregon, helping provide the OHP to approximately 275,000 Oregonians. We have learned a lot from our experience in participating in the founding of a total of five CCOs that continue to provide community based care in both rural and urban areas. We are proud of the success and gains we have made within the Oregon Health Plan through the implementation of the coordinated care model, but we know that there is work to be done to move health care transformation forward.

Health care transformation can mean many different things, and we have learned that the subjective nature of this phrase can lead to many moving targets with multiple definitions of what success looks like. As we developed the following comments, we quickly realized that there are two ways that we talk of health care transformation here at CareOregon.

The first type of transformation that we discuss is informed by our experiences within the trenches of managed Medicaid work; we know the parts of the current system that present challenges, and we have suggestions about things to consider which might make provision of the OHP more efficient moving forward. Many of our comments fall into this category, as we believe that this innovative system will best improve if the OHA and CCOs work collaboratively together. Again, we are encouraged by how open and accessible the OHA has been within this CCO 2.0 process, and we appreciate the OHA's renewed efforts to be both a regulator and partner in this work.

The second type of transformation that we discuss is well represented by the out of the box thinking that guided the founding principles for the coordinate care model: creating a health care delivery system that achieves the triple aim through value based care which addresses the specific medical and non-medical needs of the community. Oregon took a major step forward by establishing CCOs that accept risk, develop alternative based payment methodologies, integrate behavioral, oral and physical health, and invest savings back into the community to address the social determinants of health. CareOregon believes that transformation is not possible without holding CCOs reasonably accountable for how well we have adhered to the original vision, and we encourage the OHA and the OHPB to build on the transformation envisioned when CCOs were established.

We hope that these comments will help move both types of transformation forward, and we look forward to continuing this journey with you in the immediate future.

Sincerely,

Eric C. Hunter
President and CEO
CareOregon, Inc.

Sustainable Spending and Controlling Costs

Through our work to achieve the triple aim within the 5 CCOs that we have supported over the last 5 years, we have gained insight into the gap between the academic goals of the coordinated care model, and the reality that we see in the day to day operations of a managed Medicaid plan. We believe that the coordinated care model could be improved if CCOs and the Oregon Health Authority (OHA) worked more closely to address the true cost drivers of health care. Furthermore, we believe more work must be done to clarify the difference between actuarially sound rates, and sustainable funding for the Oregon Health Plan (OHP). Short term solutions to these issues include multi-payer collaboration on cost containment, more efficient reserve requirements, addressing the threat of benefit package inflation, and better collaboration with the OHA on financial data reporting.

Health Care Cost Drivers

The coordinated care model envisions managed health care plans that achieve the triple aim through providing a better health care experience for individuals and populations while bending the cost curve. CareOregon is proud of the gains that our CCOs have made through better utilization management practices, and alternative payment methodologies that prioritize quality care and access for our members. However, we would like to work more closely with the OHA to control costs that seem to fall outside what the CCO has authority to manage. Any direction from the OHA which would lead to enhancing the ability (and necessity) of CCOs to truly manage the whole patient through truly integrated care models is critical to long term success.

A portion of CareOregon's membership receives health care through CCOs that serve rural geographies. We rely on Type A Hospitals (remote hospitals with 50 or fewer beds, more than 30 miles from acute inpatient care facility) and Type B Hospitals (rural hospitals with 50 or fewer beds, 30 miles or less from another acute inpatient care facility) to provide health care to our members in many parts of rural Oregon. We would like to work with the OHA to either develop rates that accurately consider the cost of hospital care, or for the OHA to partner with CCOs to help negotiate rates with hospitals that align with the cost trend that the agency seeks to achieve. Considering the decrease in uncompensated health care that accompanied Medicaid expansion through the Affordable Care Act, CareOregon would also like to work with the state to identify fixed, hospital rate additions which were originally intended to cover uncompensated care.

The rising costs of care provided by hospitals, coupled with the national problem of high cost pharmaceutical drugs, both call into question which cost trends CCOs can control. We acknowledge that our organizational Medical Loss Ratio (MLR) currently exceeds our target of 90%, and that there is work that all CCOs can do to help contain costs within our respective health plans. CareOregon will continue to find ways to be innovative in our pursuit of the triple aim, however, Oregon's 1115 Demonstration Waiver with the federal government caps growth of the Oregon Health Plan to 3.4% which may not adequately consider the evolution of health care cost drivers within the last five years. CareOregon would support efforts to determine whether 3.4% is the right trend target due to the unforeseen rise in costs for both drugs and hospital provided care. A better understanding of how the 3.4% inflationary cap impacts CCO sustainability may provide more clarity around how we can align rate setting to achieve Oregon's public policy objectives.

To better assist CCOs with their work to mitigate rising medical costs, our CCOs strongly believe that both regional and state-wide utilization benchmarks be made available to the CCOs. Without benchmarking, it is a challenge to evaluate how we are doing as a managed care insurance entity. The first step to improving cost trends is understanding the drivers, and how each CCO compares its performance to others.

Benefit Inflation and Actuarial Soundness

CareOregon has ongoing concerns regarding threats to the work of the Health Evidence Review Commission (HERC), and the subsequent inflation of the Oregon Health Plan benefit package. We hope to work with the OHA and the Oregon State Legislature to ensure that Oregon's Prioritized List can continue to evolve and produce a stable, evidenced-based benefit package so that CareOregon can budget appropriately. CareOregon also suggests the OHA consider more aggressive efforts to move the Medicaid population diagnosed with End Stage Renal Disease (ESRD) into more appropriate care through the Medicare program. CCOs should work to make sure that the needs of the member are prioritized in these transitions, however, the OHA should help facilitate the movement of this population into a more appropriate health plan.

CareOregon believes that the rates we are paid by the OHA to provide the OHP are actuarially sound; however, we do not believe that an actuarily sound rate should be confused with a payment rate that offers sustainability to managed Medicaid plans with the added responsibility of investing in long term system transformation. We believe that the profit margin considered in rate setting should remain low; however, we urge the OHA to consider more than the lowest care utilization assumptions when determining the cost to provide care within the OHP. In the range of health care utilization possibilities present within each rate setting process, picking the lowest estimation of potential health care utilization has resulted in consistent underpayment for CCOs.

Currently, actuarially sound rates do not adequately consider the upstream investments that CCO's make to build infrastructure and capacity for health care transformation. To be clear, CareOregon does not believe that every conceivable expense incurred by a CCO should be included in the rate setting process. However, Oregon's CCO financial policy and rate setting process should acknowledge the disconnect between what CCO's are expected to invest in, and what resources are made available for these investments.

Innovative Funding Opportunities, Policy Alignment and Financial Reporting

CareOregon would appreciate the opportunity to work with the state on innovative ways to braid multiple funding streams. Federal funds are often categorized in a way that make it difficult for CCOs to develop innovative models that efficiently and effectively use these dollars. Substance Use Disorder funds, ACT funding, and the OHA/DHS split in funding for high risk youth all present examples of siloed funding that could be better aligned to benefit the intended population.

The OHA also can align other state efforts to control health care costs with the CCO rate setting process. A clear example is presented in the opportunity to ensure adequate support in CCO budgets for statutory requirements to spend 12% of a CCO budget on primary care. If Oregon's policy goal is to increase primary care investment through innovative value based purchasing (VBP) models, then Oregon must do more to integrate these models into a CCO rate setting process that accounts for the inability of

encounter data and claims data to capture innovative VBP models. The state should also apply this work to multiple levels of publicly funded health insurance, and not restrict these new mandates and requirements to Medicaid plans alone. Oregon's health care providers often serve more than just OHP members, and provider uptake of innovative payment arrangements could greatly increase if these arrangements and requirements applied to more than just the Oregon Health Plan.

CareOregon recommends a technical change to CCO reserve requirements. Currently, rates are not structured in a way that allows CCOs to accrue reserves. Considering the challenges posed by limited financial resources and multiple CCO models, CareOregon suggests allowing the reserves of a CCO's risk bearing entities to be counted towards the statutory reserve requirements for CCOs. This would better allow trapped reserves to cover risk while adding liquidity to the system.

Finally, we ask the OHA to consider CCO data reporting capacity issues when developing new financial reporting requirements. To be clear, CareOregon believes that adequate data is necessary to accurate rate development, and that CCOs have a responsibility to be an active participant in the data transfer process. However, we must acknowledge the burden that accompanies misaligned reporting requirements. We urge the OHA to consider the administrative burden, both in cost and personnel, that new reporting requirements might add to the CCO workflow.

Value Based Payments

CareOregon supports the OHA's efforts to increase Alternative Payment Methodologies (APMs) as a way to expand the use of Value Based Purchasing (VBP) within the Oregon Health Plan. CareOregon has worked with the nationally recognized Health Care Payment Learning and Action Network (LAN) to further define and develop APMs. LAN was formed in 2015, and has been working with hundreds of organizations to collect data on APM adoption, with the goal of tying 50% of health care payments to APMs by 2018. We are encouraged to see the OHA build upon the national work started by LAN, and urge the agency to continue to use the work of LAN for guidance as Oregon works to expand APMs into new areas of health care.

CareOregon is also encouraged by the work of the OHA led Primary Care Payment Reform Collaborative. CareOregon supports the OHA's efforts to collect data on the large number of APMs currently taking place within Oregon. We believe that this APM landscape assessment will help the OHA develop minimum standards for how CCOs can expand the use of APMs.

While CareOregon supports APMs as a useful tool to increase value based purchasing of health care, APMs are not appropriate in every health care setting. CCOs need more clarification, guidance and transparency around how VBP/APMs will be measured and incorporated into future rate setting. Some CCOs have been subject to reductions or "base data adjustments" which may have reduced confidence in the ability for VBP investments to be accurately accounted for within the rate setting process, subsequently inhibiting VBP further investment. CareOregon currently develops APMs to supplement the base rate that we pay providers for care. As we shift towards a VBP environment, we would like more clarity from the state about which VBP models we should invest in moving forward. We urge the OHA to align VBP policy priorities with efforts to develop a CCO global budget that can more sufficiently serve a membership subject to daunting health care challenges impacted by social determinants of

health, and we ask that OHA better align payments with how CCOs invest in social determinant interventions within each community.

We support the OHA's collection of data on APMs because we know that our ability to engage in value based payments depends on our provider's capacity to participate in VBP initiatives. Efforts to expand VBP should consider the limitations that accompany provider capacity within specific CCO service areas. To spread the adoption of value based purchasing through APMs, the state should leverage the contracting authority that exists within both PEBB and OEBB. Furthermore, the state should collect data on APMs from CCOs and all other insurance providers that receive public funding. Efforts to expand adoption of VBP within a provider network will be more successful if alternative payment models can apply to larger populations of people seen by each provider.

Behavioral Health

CareOregon supports efforts to make CCOs responsible for the adult mental health residential benefit, but we also urge the OHA to utilize learnings from our "early adopter" experience from attempting to integrate this benefit into the CCOs we are connected to; our experience could help the state guide through the challenges that may accompany transferring this benefit to other CCOs. We still believe that CCOs are best positioned to develop a comprehensive system of care for this population, and any effort to improve behavioral health integration should include work to incorporate this benefit into the scope of each CCO.

CareOregon also believes that CCOs should enter into risk sharing agreements with the state hospital to support the Oregon Performance Plan requirements and allow CCOs to invest savings from reduced lengths of stay into community based solutions that would prevent the need for that level of care.

Finally, youth with special health care needs should not be segregated into a population specific CCO. Pulling children out of the community based CCO would work against the values and principles that underpin the local systems of care and Wraparound programs that CCOs were designed to build. The local support that accompanies community-specific systems of care remains an important facet to the coordinated care model and creates the ability to keep children and youth in their home communities. CCOs were developed to be the single entity to coordinate disparate parts of the health care system as needed by the community; population specific CCOs would represent a step backwards by separating what we have spent the last 5 years working to bring together.

Social Determinates of Health and Equity

CareOregon is committed to meeting the needs of the communities that we serve by addressing the unique social determinants of health (SDoH) that impact different parts of Oregon in different ways. We work to make sure our investments in strategies to mitigate the SDoH are driven by the community, and that we identify community needs through our Community Advisory Councils and Community Health Improvement Plans. For these reasons, we are in strong support of the SDoH research and guidelines produced by the OHA's Medicaid Advisory Committee (MAC) throughout the last few years.

We agree that CCOs can use a number of community benefit financial resources, collectively known as Health Related Services (HRS), to address social determinants within our service areas.

CareOregon has also worked to address inequities in the provision of health care and resources within the communities we serve. We believe that issues of equity are not limited to the provision of health care, or the expenditure of grant dollars to the community. We believe that our organization must reflect our commitment to equity within our hiring practices, culture and overall mission. CareOregon supports efforts to further strengthen the coordinated care model's commitment to equity, and we look forward to working with stakeholders about what this should look like.

While there are certainly places for improvement regarding the way in which CCOs address SDoH and equity, we believe that the OHA must do more to understand the work that CCOs have done within these areas. Currently, there seems to be consensus that the flexibility provided to CCOs in how they address SDoH has allowed troubling variability in CCO community investment. CareOregon believes that it is time to increase accountability for CCO investment in SDoH, but we are concerned that the state may not know enough about the various investments in SDoH to accurately identify problems, much less, solutions. This is yet another reason why we support the recommendations put forth by the MAC; these recommendations represent a foundational starting place for the beginning of the conversation regarding how CCOs should make community investments to address social determinants.

We urge the OHA to use the Transformation Center to better catalogue and distribute information about what CCOs are doing to address social determinants in the communities that they serve. Our CCOs would benefit from sharing best practices and learning from what other communities are doing to tackle the social determinants of health and equity. Furthermore, more effort to review how CCOs use HRS to address SDoH will help the state better identify what works, what does not work, and what gaps remain. Finally, we would also caution against CCO SDoH investment policies that create a "one size fits all" approach to community investment. CCOs should be community based, and each CCO has the obligation to adapt and respond to the needs of the community in innovative ways that should not be constrained by well intentioned, but potentially harmful, policies advocating specific investment strategies.