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Tuesday, November 27, 2018

OHA Director Pat Allen
500 Sumer St NE
Salem, OR 97301

RE: Enrollment and Rate Public Comment

Director Allen,

We would like to thank you for the opportunity to comment on the new proposals put forth by the Oregon Health Authority about both enrollment and rates in the new CCO 2.0 Request for Application.

Enrollment:

Enrollment of OHP members is a vital part of a member's health and wellbeing. We completely agree with the statements at the public meeting on November 19th that the number one goal in developing policy around enrollment needs to be the wellbeing of the member.

It has been this organization's experience that anytime there is a transition of health coverage there are serious health risks to members. This can come from a loss of care coordination programs, members end up on a plan that doesn't contract with their long term health provider resulting in a break in their continuity of care, disruptions in the patient provider relationship, lack of knowledge about the specific needs of the new member, issues with getting prescripts for members, etc...

These are all concerns when members are actively making decisions during open enrollment. However, members and plans can work together mitigate these concerns and make the transition successful. The problem is for many of the OHP members the Oregon Health Authority doesn't have the most current contact information. This means members don't hear about what their actions (or inactions) could do to their health care coverage.

Members that are sent to a different plans will likely not know about any coverage complications until they try to access care, meaning when our OHP members need help the most is when the complications from the coverage transition are most likely to happen.

Switching people back to their original plans is not a quick process (could take up to 90 days). This process can be laborious for the member and CCOs cannot help them with enrollment. This means members could be in Fee-for-Service for quite some time and may lack access to their provider and other needed services.

This is further complicated if members are transitioned back to their plan after 60 days. They are then not included in the statewide health metrics. This could lead to some serious issues around measuring the health of the OHP population.

AllCare Health supports an opportunity for our OHP member to select their preferred plan through an open enrollment process if change in coverage takes place, but if a person doesn't make an active decision to change to a new plan then they should return to the plan they were previously in. By doing this we will have a much greater chance of protecting the continuity of care for all our OHP member and protect their extremely important patient provider relationship.

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In the best interest for the continuity of care and protecting the patient provider relationship we strongly recommend selecting option 1.

We would ask that well before any open enrollment process starts, the OHA works with the CCOs to inform members about the changes in enrollment status. We would ask the state to take into account that some members will have just re-enrolled and then likely will be asked to re-enroll again a few months (maybe even weeks) later. We would also like to see the OHA start working with the MEOH Group to develop communications and make sure the CCOs can comment on the communications going out members about this transition.

Rates and Risk Adjustment:

We are extremely happy and very appreciative of the general direction of the new rate setting process that was proposed at the November 19th public meeting. We believe the two year rates cycle, statewide rate setting, and stable funding for social determinants of health (SDoH) feels like we are moving closer to a true global budget model originally envisioned in Transformation 1.0.

We do have some questions how exactly the rate setting mechanisms driving these changes would be operationalized and how the OHA will deal with some consequences from these changes.

Here are a few of our questions from reviewing the PowerPoint presentation for the public meeting:

1. Would each CCO within a region received the same geographic adjustment?
2. Will "avoidable costs" which are removed from the base data be fully removed in 2020 or will the removal be phased out? Will plans be provided with specific information regarding what is considered "avoidable costs" in order to support prospectively removing these costs form their actual cost structure?
3. Will reimbursement for social determinants of health vary by CCO or will this reimbursement be consistent for all CCOs (i.e. spend it to get it)?
4. Is the current quality pool that is calculated as a bonus now being calculated into the benefit (Basically the benefit payment have increased 4.25%).
    a. If not, then it looks as if you have cut the CCOs rates by 4.25%
    b. If yes, how exactly will this be calculated?
5. How is the state going to be transparent about how the funding for SDoH is developed on year three (i.e. will this be baked into rate or will there set-aside amount for SDoH in rate development)?
6. What is the process for developing the rules around for SDoH funding?
7. Are the criteria for calculation efficiency and VBPs going to be fully developed before 2020 so CCOs can make proper investments (since payments in 2022 will be based on 2020 data)? Will the goals and rules not be changed once they are finalized?
8. Since the CCOs are moving more towards global budgets can we look at changing the 85% MLR requirement to a new mitigation strategy to encourage more upstream health investments since many of the community SDoH investments do not count towards claim cost when calculating the MLR percentage?
9. How does the Prometheus proposal take into account variability of services/providers in different regions of the State?
10. How does the Prometheus proposal take into account the needs of the members if the provider recommends that course of treatment?
11. How does the Prometheus proposal take into account medical exceptions?
12. Will CCOs and communities (practically rural communities) have time to develop providers and services that may not be currently available but considered high value according to Prometheus?
13. How often will the specs of what is considered "value" change? Every year, three years, 5 years?
14. If the OHA is developing state wide rate/global budgets year to year, won't plans already be getting incentivize to do the low cost options making Prometheus proposal redundant?

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15. Will CCOs be required to purchase the Prometheus product to understand how the algorithms work? Will the State pay for it for all CCOs? What happens if the state stops using that program?
16. Will OHA consider recalibrating the risk score weights to account for new treatments and technologies that are not included in the latest available weights?
17. How will the OHA address benefit changes and additions between the 2 year rate setting process?

These were just short amount of questions we had from reviewing the PowerPoint presentation the last few days. We imagine that we will have more follow up questions. We also hope that our questions may help prevent unintended consequence from what are, overall, positive changes in direction.

We do still have serious concerns about some Rates and Risk Adjustment suggestions. The success of the CCOs is based largely on building strong patient provider relationships and paying for quality not quantity. One of those main tools has been Value Based Payment (VBP). We are very concerned that merging the bonus pool funds in the rates takes away surety for providers and when it comes to VBP and we would recommend not blending the quality pool dollars into the rates.

There seems to be increasing administrative costs in the CCO 2.0 recommendations with no correlating increase in the administrative rates being paid to CCOs. We would ask that the OHA work with the CCOs to price out exactly what those increases will cost so they can calculated in the administrative rates which will make these new programs sustainable.

Our providers are concerned that the Prometheus proposal creates ethical concerns around the state coming close to practicing medicine by rewarding specific kinds of care. Also concerning, operationally, is whether the Prometheus proposal is still paying per procedure (just with the OHA dictating the procedure) not based on the actual health of the members, which means it is pushing CCOs to continue thinking in a FFS way as opposed to value-based mindset. We highly recommend much further discussion and deliberations before moving forward with this proposal.

We ask that the OHA extend the public comment period a week or two to allow questions being asked about these proposals to be answered. We believe those answer will open up other helpful questions as the policies are being developed.

Finally, we ask that the OHA work with the stakeholder to develop a different option when developing a mid-year adjustment for CCOs rates in 2020. We believe that by working together we can find a third alternative that would create more financial surety for the State and CCOs as the 2020 transition occurs.

Thank you again for the opportunity to comment on both of these critically important topics. We very much want to protect the patient-provider relationship and continuity of care for our member. We therefore request that the OHP adopt option 1 for enrollment. We also appreciate the Rates setting policy direction the OHA is proposing, we just ask for more time to get questions answered to allow a fuller vetting of these programs attempting to achieve these import policy goals.

Sincerely,

Josh Balloch, Vice President of Health Policy
AllCare Health

Columbia Pacific CCO™ CareOregon® Jackson Care Connect™

Patrick Allen
Director
Oregon Health Authority
500 Summer St. NE
Salem, Oregon 97301

November 28, 2018

Dear Director Allen:

Thank you for this opportunity to comment on the member enrollment options being considered for the start of the 2020 contract between the Oregon Health Authority (OHA)and future Coordinated Care Organizations (CCOs). CareOregon is a non-profit, tax exempt 501(c)(3) that provides the Oregon Health Plan (OHP) through two wholly owned CCOs (Columbia Pacific CCO and Jackson Care Connect), participation in Health Share of Oregon (physical health risk accepting entity for 200,000 OHP members), and Managed Services Agreements with Yamhill Community Care Organization and Health Share of Oregon. CareOregon' s network of health care providers delivers the Oregon Health Plan to approximately 300,000 Oregonians.

Above all else, we would like to use this opportunity to emphasize the importance of continuity of care for the OHP member. Post open enrollment, we recognize that continuity of care efforts can be prioritized through different auto-assignment methods. The comments below reflect a need for clarity to help develop a process that puts the OHP member's care needs first.

CareOregon is looking for clarity on some of the definitions connected to the member enrollment materials provided by the OHA on November 19th, 2018. The OHA provided 3 approaches to the auto-assignment process that could potentially follow an open enrollment period for CCOs awarded a contract in 2020. In the 3 auto-assignment approaches, the terms "incumbent CCO", "newly formed CCO", and "restructured CCO" are used repeatedly; we respectfully request clear definitions for each term, and we hope that the definitions help resolve the following questions:

1. What factors would be used to define an incumbent CCO? Would the CCO have to serve the same geography and number of members? Would the provider network need to be identical or similar to the previous CCO? Would the delegation agreements of the previous CCO need to remain in place to be considered an incumbent CCO?
2. Similar to question 1, how would a CCO's structure need to change to be considered a "restructured CCO" or a "newly formed CCO"? Would a CCO be classified as "restructured" if the previous CCO continues to hold the CCO contract with the state, yet the structure of that CCO is different? If all or some of the pieces of a previous CCO form a new entity for 2020, would this be a newly formed CCO or a restructured CCO?
3. In the yet to be finalized definition of entities eligible to apply for a 2020 contract, the OHA has defined the eligible as those that have a "footprint" in health care in Oregon; this definition distinguishes between CCOs, those currently/previously licensed by DCBS, Risk Accepting Entities (RAEs) and Native American Tribes. In the scenarios that would auto-assign members based on a look back to previous enrollment, would members follow the RAEs they were previously assigned to? If previous RAEs or delegates intend to operate in

the same geographic area, serving the same population as served in the previous contract, would this be an incumbent CCO, a restructured CCO, or a newly formed CCO?

While we would need the information requested above to comment on auto-assignment options 1 and 3, based on the information that we currently have, we feel as though auto-assignment option 2 ("pause previous plan lookback") would be the most disruptive to the member's continuity of care. By ignoring an OHP member's previous CCO affiliation, Option 2 would also ignore that member's use of the provider network, including the CCO/RAE developed care management teams that keep members connected to their primary care providers. Thus, Option 2 could potentially disrupt a member's care plan through an auto-assignment to a CCO with a different provider network.

When considering how to define the different CCO structures, we encourage the OHA to consider the significant and material connection that the existing OHP membership may have with RAEs and their provider networks, regional care teams and patient-centered primary care homes. This consideration could take many forms, including membership or network thresholds that might help distinguish between incumbent, restructured and/or new CCOs. We understand that this may further complicate the process, but we believe it is important to acknowledge the fact much more must be considered when discussing how best to protect the continuity of care within OHP membership.

Regardless of which auto-assignment approach is selected, we ask that the enrollment and auto-assignment process be reasonably transparent to stakeholders, and efficiently navigable for the public that will be reprocessed into the OHP. In Jackson County, we have multiple families that have children living in the same house, but assigned to separate CCOs. Our ability to unify the family within the same CCO is inhibited by the complex and opaque nature of the OHP re-enrollment process. We know OHA and DHS are making significant strides in this work, and we encourage the OHA to continue to make this process efficient and transparent.

Thank you again for this opportunity to provide input on this important process, if we can be of any more assistance to you in the near future, please do not hesitate to reach out to us.

Sincerely,

Jeremiah Rigsby
Chief of Staff to the CEO
CareOregon

CHILDREN'S HEALTH *alliance*

November 28, 2018

To: Patrick Allen, Director Oregon Health Authority
Jeremy Vandehey, Director of Health Policy and Analytics

From: Deborah Rumsey, Executive Director, Children's Health Alliance
Julie Harris, Senior Director Population Health, Children's Health Alliance
Jay Rosenbloom, MD, Medical Director, Children's Health Alliance

RE: CCO 2.0 Public Input/Risk adjustment methodology

The Children's Health Alliance is an association of over 120 primary care pediatricians and nurse practitioners across six counties in the Portland/Vancouver and Salem Metropolitan areas. These pediatricians provide care for approximately 140,000 children in the state, including 32,000 children insured through OHP .

The Children's Health Alliance and our pediatrician members would like to express appreciation to the Oregon Health Authority for the thoughtful approach to CCO 2.0 with intent to improve transparency and equity among CCOs across the state in the rate setting process. The rate setting process is particularly important to enable the appropriate allocation of resources to children's health, which has been identified as a key strategy in developing CCO 2.0. "Investment in early childhood services and maternal and child health is a proven strategy to improve health outcomes and contain health care costs, as well as creating notable returns on investment in education costs, workforce productivity, crime reduction, and reduced burden on safety net services."[1]

We would like to highlight some considerations and suggestions related to the risk and rate setting strategies that will encourage the continued focus on the pediatric population in Oregon.

We recognize many limitations in the use of algorithm-based predictive risk analytics to effectively represent the comprehensive complexity of children's health care costs. Many indirect factors also impact care for children, including the functioning and social factors affecting guardians, families and extended care providers.

> "Many characteristics make children special: relatively low mortality and morbidity rates; specialized pediatric services (e.g., neonatal intensive care unit [NICU] care); use of providers and institutions outside the traditional health care delivery system (e.g., school health clinics); and the need for adult help and supportive environments. These considerations often make risk adjustment more challenging for children than adults. …family and community factors strongly influence child utilization and health status. Risk therefore should be measured, at least in part, at the family or parental level".[2]

Insufficient risk adjustments for children will likely continue to create a divide in recognizing complexity of children in the shadows of higher cost adult populations. We advocate separating all children/youth age 0-18 into rate categories separate from 19+. This would help Oregon achieve the goals of CCO 2.0 related to both the pediatric and adult populations.

1 OHA 9830 CCO 2.0 Recommendations of the Oregon Health Policy Board. October 2018. Retrieved from https://apps.state.or.us/Forms/Served/le9830.pdf

2 Risk Adjustment for Pediatric Quality Indicators. AAP Publications www.aappublications.org/news Karen Kuhlthau, Timothy G.G. Ferris, Lisa I. Iezzoni. Pediatrics Jan 2004, 113 (Supplement 1) 210-216.

Specifically, there are compelling arguments for the need to separate risk adjustment for the 0-18-year-old population within the Blind & Disabled aid category as well as considering not applying Prometheus analytics to this child population in the same manner as adults. Children/youth have different desired care goals than adults and therefore different costs/investment, including a much higher preventive care ratio, more compounding social determinants of health (SDOH) impacts due to dependency on guardians for health management, and a need to invest in services that may impact long term health if provided at an early age.

- As CCO 2.0 strives to encourage consideration of SDOH and the state advocates for higher rates of kindergarten readiness and improved behavioral health services for children, separating the complexity and unique needs of children from the adult rate categories will prove increasingly important.
- Oregon enables children in households up to 300% of the federal poverty level to qualify for state health care, which is approximately 50% of children/youth in our state. This population is larger and distinctly different from low-income and disabled adults. Separate rate groups enable us to dive deeper into understanding the needs and appropriate policy supports for children/youth.
- Variation in care protocols across ages of children/youth creates administrative complexity and nuances in what care is covered under state health plans for children – these complexities warrant separate risk/rate categorization from adults, especially as CCO 2.0 plans to encourage building capacity of needed services.

More specific detail outlining additional considerations and implications of using standard risk adjustment and rate setting methodologies for children, as well as utilization-based analytics, are outlined in Appendix A. We urge OHA to review this rationale and consider addressing the pediatric population separate from their adult counterparts based upon our organization's experience related to risk adjustment, rate setting and efficiency analytics for the pediatric population.

CCO 2.0 is an opportune time for our state's risk adjustment and rate setting policy to fully stratify the population of children into distinct rate categories for all members age 0-18. This enables positioning for CCO 2.0 goals and an increased understanding and response to the complexity of the children and youth in whom our state is investing.

We applaud OHA's thoughtful consideration of the rate setting process in CCO 2.0, and appreciate the opportunity to share our pediatric-specific experience in risk adjustment and rate setting. Thank you for considering our recommendations on behalf of the 120 primary care pediatrician members of the Children's Health Alliance. Please let us know if we can provide any further information.

Julie Harris, Senior Director Population Health, Children's Health Alliance

Deborah Rumsey, Executive Director, Children's Health Alliance

Jay Rosenbloom, MD, Medical Director, Children's Health Alliance

1 OHA 9830 CCO 2.0 Recommendations of the Oregon Health Policy Board. October 2018. Retrieved from https://apps.state.or.us/Forms/Served/le9830.pdf

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Appendix A

1) Risk Adjustment for Pediatric Populations:

There is general consensus amongst provider groups focusing on children, that no current predictive risk allocation model adequately/appropriately categorizes children based on expected cost of care. In addition, historic coding practices in children's care grossly underestimates the complexity of the population for several reasons.

a. The broadly utilized CDPS+Rx model, while originating in Medicaid, offers many disconnects in predicting costs of care for children. For example, it does not offer risk adjustment for prematurity, fetal alcohol syndrome, nor Type I diabetes in children. Further, many relative risk adjustments are counter-intuitive to providers. For example, certain diagnoses for nose-picking or thumb-sucking have risk adjustments 60% higher than anorexia nervosa.

b. Developing more consistent recurrent coding practices for chronic diseases in pediatrics will improve visibility to the complexity of the pediatric population. It will take several years of recurrent diagnosis coding improvement for risk adjustment calculations to more accurately reflect pediatric population complexities and costs.

c. The practice of coding to lower specificity is believed to be common in pediatrics and contributes to under-representation of the complexity of these populations. There is a trauma-informed care culture in pediatrics to use "soft" coding and diagnoses descriptions since it is devastating to most young families to hear of a severe diagnosis in their child. So, a pediatrician may code for general developmental delay instead of coding to the highest specificity which might be severe mental retardation. In addition, a very clear developmental, mental health, behavioral, or neurological diagnosis is not always evident for quite some time (years) with children. We treat the presentation with evidenced-based approaches, but it is inappropriate to give a diagnosis just to enhance needed funding or coverage for services. Children develop over time and very often the diagnosis becomes much clearer with their response (or lack thereof) to interventions.

d. Access to pediatric services can often be constrained in our state. For example, current capacity underserves demand for services such as early intervention and mental/behavioral health. It can be typical for a family to wait 9 months to get a developmental diagnostic appointment. Some estimates show that only approximately 20% of families in need will access specialty mental/behavioral care. When access limits utilization, and utilization and its associated diagnosis is informing rate setting analytics, how is this gap addressed in the CCO 2.0 plan? There is mention of encouraging capacity building which is very relevant in pediatrics. How will the risk adjustment processes account for and align with this goal?

We anticipate a continued under-representation of the complexity of pediatric populations via risk modeling in our state for the foreseeable future. OHA would benefit from isolating the population of children (age 0-18) from adults and studying the validity of available models such as the Pediatric Medical Complexity Algorithm (PMCA+Rx). Some work is underway in our state currently with PMCA and SDOH data that could catalyze progress in understanding complexity and risk of pediatric populations. We encourage OHA to actively analyze the viability of these models to better describe the complexity and risk of pediatric populations.

1 OHA 9830 CCO 2.0 Recommendations of the Oregon Health Policy Board. October 2018. Retrieved from https://apps.state.or.us/Forms/Served/le9830.pdf

2 Risk Adjustment for Pediatric Quality Indicators. AAP Publications www.aappublications.org/news Karen Kuhlthau, Timothy G.G. Ferris, Lisa I. Iezzoni. Pediatrics Jan 2004, 113 (Supplement 1) 210-216.

2) Prometheus analytics for pediatric populations:

Encounter-based, and utilization-based analytics such as the described Prometheus analytics tool, are usually subject to very similar complications related to pediatric populations. Additional analysis and evaluation of the impact on the pediatric population is encouraged; "avoidable" and "efficient" use of health care services in the pediatric population looks very different from the adult population since pediatric utilization varies across stages of development.

Children/youth have different desired care goals than adults and therefore different costs/investment. Pediatric care involves a much higher preventive care ratio. In the Prometheus analytics, preventive care and newborn care are outlined in the "other" category of considerations. Are there effective methodologies for valuing preventive pediatric care? Does the methodology to evaluate efficiencies in healthcare delivery properly reflect the different need for services in the pediatric population? Does "avoidable" utilization account for the changing needs of the developing child?

To mitigate unintended analytical conclusions, we advocate that the state invest extra time to evaluate pediatric populations via the Prometheus method and any other promising models prior to applying this to rate setting for the 0-18 year old population.

3) Risk/rate setting for pediatric populations:

While our state prioritizes children's health care and services, it does not yet distinguish all 0-18 year old Medicaid members into separate aid categories for rate setting and risk adjustment. We anticipate that applying both Prometheus analytics and insufficient risk adjustments to children will likely continue to create divide in recognizing complexity of children in the shadows of higher cost adult populations. This can lead to ineffective rate setting for children which are a very highly prioritized population in our state.

a. For example, in the Blind and Disabled aid category, a child with developmental delay/autism will be adjusted in comparison to a low-income, disabled, adult with cancer, heart failure or dialysis. In our experience, we've seen this equate to an average risk adjustment as low as 0.13 for the 0-18 year old's in this aid category. This essentially creates two distinct tiers in one category – children versus adults. The accuracy of each is diluted and compromised, and funding intended for children may be shifted to adults.
b. The impact of SDOH on children can be indirect and compounded due to dependency on guardians for health management. Achieving reliability with simple parent-child relationships in data sources are difficult at best, so associating the impact of social and family functioning on children is increasingly complex.

1 OHA 9830 CCO 2.0 Recommendations of the Oregon Health Policy Board. October 2018. Retrieved from https://apps.state.or.us/Forms/Served/le9830.pdf
2 Risk Adjustment for Pediatric Quality Indicators. AAP Publications www.aappublications.org/news Karen Kuhlthau, Timothy G.G. Ferris, Lisa I. Iezzoni. Pediatrics Jan 2004, 113 (Supplement 1) 210-216.

November 28, 2018

Director Pat Allen
500 Summer St. NE
E-20
Salem, OR 97301

Dear Director Allen,

First and foremost, thank you for the work that you and the Oregon Health Authority (OHA) have done to ensure that the CCO 2.0 procurement and rate setting process is transparent and open to input from stakeholders. We especially appreciate the increased attention to the need for stable funding of Social Determinants of Health. It is our position that these steps are integral to moving our member CCOs towards operating under a true global budget and we appreciate your effort to help move the state in this direction.

As a coalition of CCOs whose membership accounts for over 400,000 Oregon Health Plan (OHP) recipients, we thank you for your focus on our members, their existing provider relationships, and the population healthcare needs of individual communities. Because we value existing healthcare relationships for ensuring continuity of care for members, we would like to echo comments shared by providers, provider groups and others at the November 19 public meeting to maintain continuity of care between members and their Primary Care Provider through the auto-assignment approach #1. We would, however, like further clarification as to how financial viability will be evaluated, what observations the OHA has made through the first contract period that may inform your evaluation, and whether an initial financial viability test would be followed by a stringent on-going evaluation process to ensure the overall stability of the whole system.

While we recognize the good work and effort that has been put into the CCO 2.0 process, some of the changes discussed in the "CCO 2.0 Rates and Risk Adjustment" session are significant and far reaching. We would appreciate the opportunity for additional meetings with experts and stakeholders throughout the system, including clinical experts, to ensure that any unintended consequences are appropriately considered. There are some concerns we would like to raise regarding the implementation of the Prometheus Model, the rate setting and risk adjustment proposals, and the quality pool arrangement set forth in the public meeting held on November 19, 2018.

Prometheus Model:

We believe there are important considerations in the Prometheus Model of adjusting for efficiency that have yet to be addressed and we look forward to working with the OHA and Optumas on any unintended consequences that can be mitigated. We believe it is important to ensure that any dollars removed from rate development are both theoretically and practically removable by CCOs in partnership with providers so that reductions are reasonably achievable given real clinical and administrative barriers to care management and replacement costs. Additionally, we hope that Optumas will also work to identify dollars that are not spent today and consider upward adjustments to rates to incentivize those investments when appropriate as well.

Rate Development and Risk Adjustments:

Geographically, COHO members range from the southern Oregon border to the Mid-Willamette Valley. This puts us in a unique position for seeing first-hand how the proposed regional adjustment model would affect various populations of OHP members. While it is understandable that different regions are predisposed to different health needs, it concerns us and seems unclear as to whether any given CCO in a region would receive the same geographic adjustment, instead of allowing variance between CCOs, as their population's needs and services dictate. We know that CCOs have crafted their plans in response to the communities that they serve, and think it is important to include appropriate considerations for all of the regional and statewide nuances in a stakeholder conversation about how the regional adjustment model incentivizes improvements throughout the system.

Member CCOs are also unclear as to if "avoidable costs" will be removed from base data entirely in 2020 or if there will be a phase out period. What will be the timeline for plans being notified if "avoidable costs" are found? Will the plans have the option of being proactive to remove these costs so that they might best support their cost structure, or will this be an "at notification" removal? There are also concerns that the statewide averaging and performance reward for efficiencies may be double counting the same thing. We appreciate that Optumas is looking into using multiple years of data for each rate development period, which we believe will better smooth out variation from year to year, and further recommend that, although a full data development will only be done bi-annually, OHA should collect data annually and review each year for emerging trends as part of the rate development process.

It is our hope that we can partner with the OHA to ensure that we are bolstering the right regional differences and adjusting for risk in a way that better stratifies children and vulnerable populations. We recommend using health-based risk adjustments for Children in Adoptive, Substitute, or Foster Care (CAF) rate cell, splitting existing ABD rate cell into adult and children rate cells, with separate application of risk adjustment and continuing to study appropriate ways to capture disproportionate health status based risks for rate cells which are not currently risk adjusted (e.g. Children 0-1, Duals, and others).

We recommend the state find a way to appropriately mitigate the disproportionate risks between health plans without eliminating the incentives for CCOs to manage the costs of their members

during the first of half of the year, Option #2: Retroactive Adjustment might accomplish this, but OHA may want to consider finding an alternative way that would cause less disruption.

Quality Pool to Withhold:

Moreover, there is extreme concern with moving the quality pool to a withhold without a robust discussion with the OHA, CCOs, and provider stakeholders to better understand the implications of such a change. We would like to better understand if and how, this change will remove money from the system. To the extent that the quality pool dollars are meant to incentivize certain behaviors by CCOs, then they should be retained by CCOs and not assigned to a particular purpose. Our member CCOs are wary that providers would not share in the downside risk especially with the lack of surety the withhold model creates. At a time when the OHA is intending for CCOs and providers to enter into enhanced VBP arrangements in order to improve outcomes as lower costs, we want to ensure that the conversion of the quality pool to a withhold is performed in such a way as to avoid compromising CCO 2.0's goals.

Additionally, given the heightened focus on Social Determinants of Health (SDoH) and its funding, we would appreciate a demonstration of how this payment policy would change the flow of funds. Would all CCOs receive the same amount of SDoH funding? Would it be proportional to the population? Would funding be dependent on a CCO's history of SDoH success initiatives? If CCOs made these investments, would that pool be replenished so there would be a consistent incentive to spend on these programs? What would be the process to ensure transparency in SDoH funding and spending by CCOs?

As an addendum to this letter, please find a guide we think could help inform a stakeholder discussion with OHA regarding these new payment policies. We look forward to continuing to work with the OHA and Optumas to ensure that these new policies will be implemented in a way that continues to serve our members by ensuring the long-term sustainability of the delivery system.

Finally, we would like to stress again the importance of protecting our plan members. Given these proposals, we feel that it is increasingly important to call out that these changes would affect the healthcare delivery for nearly 1 in 4 Oregonians and should be given careful and lengthy consideration.

We appreciate your allowing us to ask these questions and look forward to discussing the answers with you.

Sincerely,

Paul Phillips
Executive Director
Coalition for a Healthy Oregon

OHA Stakeholder group Payment Discussion Guide for CCO 2.0

The following topics be covered, preferably through examples:

- Implications for Overall Funding Level
    - Please describe if and/or how the change to move the quality pool from an incentive to a withhold will remove money from the system, using the following example:

$PMPM	Rating Period (incentive)	Rating Period (withhold)	Change
A. Base Revenue trended to rating period	430.31	430.31	
B. Quality Pool % (base period)	4.25%	4.25%	
C. Quality Pool % (rating period)	5.00%	5.00%	
D. Quality Pool Dollars earned in base period trended to rating period (A x B)	18.29	18.29	
E. Portion of D shared with provider (53% of D)	9.69	9.69	
F. Base Revenue for 2020 *Calculation of F*	430.31 *A*	440.00 *A+E*	
G. Maximum Capitation Dollars (assuming 100% quality earned) *Calculation of G*	451.83 *F* (1+C)*	440.00 *F*	(11.83)
H. Minimum Capitation Dollars (assuming 0% quality earned) *Calculation of H*	430.31 *F*	418.00 *F * (1-C)*	(12.31)

        - This amounts to more than 2.5% of revenue, assuming the 53% figure from previous rate cycles still holds, and this reduction would be distributed equally among all CCOs, regardless of their individual historical earn-back amount and/or distribution of quality pool funds to providers.
        - At the same time, we recognize that the Social Determinants of Health pool and the performance reward each provide additional avenues for those funds to be repurposed and enter back into the system. Can you provide a walk through to demonstrate this change in the flow of funds, or alternative considerations to explain the change in payment policy?

Additional Topics and Examples:

- **Scenarios:**
    - For all of the below scenarios, please walk through the calculations below to illustrate the proposed change assuming 4 CCOs statewide (for simplicity, we may want to omit variance in costs and risk adjustment for this example, but we should bear in mind that they would impact the final results):
    - Each CCO earns the same amount, each CCO shares the same amount of what they earn (we understand that the average is around 53%)
    - Each CCO earns the same amount, CCOs share in their earnings in different proportions (we understand there may be significant variation between CCOs with regard to this amount)

- Each CCO earns a different proportion, each CCO shares the same proportion of what they earn

- **Calculations:**
  - Base Year Capitation Rate Development
    - Statewide average of medical portion of capitation in base year
    - Prior year quality pool funding paid from OHA to CCOs in the base year in the form of an incentive
    - Portion of quality pool funding actually spent by CCO
    - Each plan's contribution of quality pool spending to base medical in the base year (zero if incentive, non-zero if withhold)
    - Non-medical portion of capitation in base year
    - Current year Quality Pool funding, either as an offset to capitation (withhold) or as an adjunct to capitation (incentive)
  - Base Year Expenditures
    - Medical dollars to providers (not quality pool)
    - Quality pool % earned by providers
    - Dollars paid by CCOs to providers (quality pool funds)
    - Challenge pool funding if applicable
    - Actual administrative expenditures
  - MLR calculation and remittance, with different treatment of incentive and withhold to conform with new CMS regulations:
    - Incentive dollars can be excluded from the denominator
    - Withhold dollars actually earned back included in the denominator
  - Profit
    - Different profit margins for different CCOs depending upon their variable earn back and sharing of quality pool funds
    - Difference between actual profit margins and amount priced into rates
    - Next Year's Capitation Rate build
      - Statewide average of base year expenditures, including quality pool and base medical, depending upon the methodology
      - Calculation of portion of withhold not reasonably achievable to be built into rates (for withhold example only)
      - Expected profit for each CCO based on actual expenditures, withhold actually earned back or incentive actually earned
      - It is important to discuss any historical expectations regarding the parties that shared in the quality pool incentives and what those parties should expect today
  - Please build any expected or intended changes to provider payments as a result of these changes into your examples
    - For example: to the extent that the quality pool dollars are meant to incentivize certain behaviors by CCOs, then they should be retained by CCOs and cannot be assigned to any particular purpose.
    - This arrangement moves the risk sharing from an upside only model to an upside/ downside model, which allows for negative margin for CCOs (as margin is 2% and the withhold is 5%)
    - If CCOs are not able to transfer any of the downside risk to their provider networks, profits and losses could vary quite significantly from year to year.

- Please share any thoughts regarding OHA's intention regarding the sharing of this downside risk and the corresponding removal of upside risk between CCOs and their provider network
- Please share your thoughts about how this change might work alongside the transformation under CCO 2.0 to move to a more significant level of APMs
- What impact might this have on future rate growth and growth of provider payments?

CCO 2.0 Rates and Risk Adjustment
Attachment to Feedback Letter
Additional Questions and Concerns

Sent on the behalf of CPC and JCC

2020 Risk Adjustment

1. Will OHA consider using a withhold / settle-up process that is revenue neutral for prospective risk adjustment in 2020? This will help OHA avoid using a risk corridor or contract amendments for the first half of the year.
2. If OHA and Optumas decide to use the risk corridor method for the first half of 2020, how will OHA and Optumas adjust benefit-related revenue for benefit costs not reflected in encounter data since the risk corridor calculation would only use encounter data expenses? This seems like a significant limitation of a risk corridor methodology, and could have material unintended results at the CCO level.
3. Similarly, how would OHA handle the risk corridor adjustment given that it likely would not be budget neutral and could have implications for whether global budget requirements are met or not?
4. Would a risk corridor methodology of this magnitude be allowed by CMS for rate certification?
5. Please provide additional information on how and when "reasonable" growth target ranges will be set at the CCO program level.
6. Will growth target ranges be set by geographic area, or on a state-wide basis?
7. Will growth target ranges be similar for CCOs competing in the same geographic areas?
8. Will growth target ranges be set in aggregate (total membership) by CCO, or will they be established by rate cell and/or by type of service?
9. Will growth target ranges be established with recognition of higher AB hospital trends?
10. What will be the process for establishing growth targets --- will it be a collaborative process with the CCOs?
11. Please provide additional information on the mechanism for accessing efficient and quality care, and how those measurements will be translated into CCO incentives
12. Are Optumas and OHA going to use different area factors for different benefits? For example, will Medical area factors be different than Dental area factors?

Rating Areas and Area Factors

1. What data source will OHA and Optumas use to calculate area factors? Will CCOs whose footprints span multiple rating areas be submitting rating-area specific cost templates?
2. Will OHA and Optumas use different admin / non-benefit expense loads by geographic area?
3. How frequently will OHA and Optumas be updating area factors? If annually, will new area factors be phased in gradually or all at once?
4. Will AB Hospital Risk Adjustment be revenue neutral at the geographic area level or will there be a transfer of payment between because of AB-Hospital mix?
5. What will be the process for "working through the significant normalization process to ensure accurate area factors for reimbursement"?
6. How and when will this normalization process be communicated to CCOs? This proposed change will generate many questions, and sufficient time for evaluation is critical.
7. Due to the complexity, CCOs will need this normalization process to be transparent (across CCOs and geographic areas), and to be fully documented for rate-setting transparency.
8. How will the State ensure that the final area factors are the result of a collaborative evaluation and decision-making process with the CCOs?

Base Data Questions

1. Will OHA and Optumas adjust for morbidity differences between years if updating base data every other year rather than annually?
2. Will geographic factors be updated on an annual basis?
3. What is the proposed year for base data for CY 2020 (preliminary and final rates) and then for CY 2021 ?
4. What preliminary rate information be shared with CCOs as part of the RFP process?

Quality Pool / Social Determinants of Health Pool

1. Social Determinants of Health Pool
    a. Will there be a lag between when the SDOH pool is measured and paid or will the SDOH pool be paid prospectively?
    b. What metrics will be used to measure, calculate, and allocate the SDOH pool?
2. Will the quality pool in 2020 and forward be considered a withhold or a bonus payment?
3. Please describe in greater detail how the state will develop and use a SDOH risk score methodology.
4. Are there other state Medicaid programs that currently use a SDOH risk score methodology?
5. How will SDOH funding for years 2020 and 2021 be established? CCOs need to understand the estimated funding as soon as possible, to plan for high value spending by 2020.
6. Please provide additional insights on how CCO investments (spending & ROI) will be measured for rate setting purposes. Many investments are inherently focused on bending future cost growth trends --- requiring a longer term of focus for ROI. Some aspects of SDOH can be easily quantified, but there are also subjective aspects (best practices and common sense) that should be considered, and incorporated into the evaluation.

Prometheus

1. Please provide more information on how this will be done in a transparent fashion, and what reports and analysis we can expect to be shared by ASU/Optumas.
2. Every CCO has both data and provider contracting nuances that would affect a Prometheus evaluation. What will be the process to ensure a fair evaluation across geographic regions and CCOs?
3. Because this analysis will be new, and will most likely would result in a reduction of base data, ASU/Optumas will need to provide sufficient time to the CCOs for evaluation and feedback of proposed adjustments. Please provide timelines for analysis, evaluation and feedback.
4. Will OHA share detailed, “bundle” level Prometheus results with the CCOs? This could include a claim level dump with each claim mapped to a bundle. How often will OHA share these results?

Health Share of Oregon

November 28, 2018

Patrick Allen
Director
Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

Delivered via email to CCO2.0@dhsoha.state.or.us

Dear Director Allen:

Thank you for the opportunity to comment on the Oregon Health Authority's (OHA's) proposals around member enrollment and rates and risk adjustment in CCO 2.0 presented during the public forum on November 19, 2018. We applaud the OHA staff for its work to develop these policy proposals and to engage the public in the policy development process.

Health Share of Oregon is a collaborative of Medicaid managed care entities (health plans), county health and social services agencies, health systems, safety net clinics, and others serving the Oregon Health Plan (OHP) population in our region. Health Share's founding organizations came together in 2012 to begin a new partnership – designed to collaborate around, rather than compete for, limited OHP resources—to serve the large OHP population in Clackamas, Multnomah, and Washington Counties. Our experiences over the last six years, including transitioning more than 100,000 members to Health Share earlier this year, give us valuable perspective on the OHA's proposals for CCO 2.0.

Member Enrollment

Health Share supports OHA's decision to honor member choice through an open enrollment process in the event that the array of CCO options available in a member's service area changes, and there are multiple CCOs in that service area. In our previous experience as one of multiple CCOs in our service area, a large proportion of members did not choose a CCO and were, instead, enrolled through the auto-assignment process.

We agree with OHA's stated goal of continuity of care for members through any auto-assignment process. Missing from OHA's presentation was mention of primary care relationships, which we believe to be fundamental to quality care management. Of the three options presented for auto-assignment, Health Share supports "Auto-assignment approach #1: Make no changes." This option is most likely to ensure the most OHP members maintain continuity of care with their primary care providers, with as little confusion and additional effort on the part of the members as possible.

Rate Setting and Risk Adjustment

In general, we believe that we will never truly address the growing costs of the OHP without addressing the social determinants of health (SDOH) and the health effects of generational poverty. We agree that the health care system as a whole, and CCOs in particular, must focus on eliminating inefficiencies by limiting over-utilization of

lower value services. However, the drive toward year-over-year cost savings and short-term return on investment should not come at the expense of long-term upstream investments in population health.

We remain concerned that the policy decision to move the quality incentive pool into CCO capitation rates will discourage longer-term upstream investments in favor of simpler tools like provider incentive payments by subjecting the quality incentive pool to the pressures of a rate-setting cycle. Similarly, creating a 1% SDOH Investment Fund with the expectation that CCOs can replace it with earned savings within two years sets the expectation that CCOs' SDOH investments can achieve cost savings equivalent to 1% of a CCO's annual capitation in a two year period.

Thus far, Health Share has used a portion of quality incentive payments to invest in programs like our foster care advanced primary care model, kindergarten readiness collaborative, and community health worker infrastructure investment—programs for which the return on investment may never accrue to Health Share but will eventually accrue to our community and to taxpayers statewide by attempting to address the health effects of generational poverty. Our hope is that OHA seeks to balance the priorities of short-term cost savings and long-term investments in its policymaking.

With regard to the two options presented for risk adjustment in 2020, Health Share prefers "Option #2: Retroactive Adjustment" because the move toward increased value-based payment arrangements would create feasibility challenges for "Option #1: Encounter Data Risk Corridor."

Again, we thank you for the opportunity to engage in this process. We find it difficult to comment on some of the policy options, particularly with regard to the rate-setting proposals, without more details—some of which may not be known until the array of CCO applicants is known. We hope to have another opportunity to comment once more details have been released. In the meantime, please do not hesitate to contact us if we can be of assistance.

Health Share of Oregon Founding Partners

Health Share of Oregon was founded and continues to be governed by eleven health and social service organizations serving more than 315,000 OHP members in Clackamas, Multnomah, and Washington Counties.

- Adventist Health
- CareOregon
- Central City Concern
- Clackamas County
- Kaiser Permanente
- Legacy Health
- Multnomah County
- Oregon Health & Science University
- Providence Health & Services
- Tuality Healthcare
- Washington County

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November 28, 2018

Patrick Allen
Director
Oregon Health Authority
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Delivered via email to CCO2.0@dhsoha.state.or.us

Dear Director Allen:

Thank you for the opportunity to comment on the Oregon Health Authority's (OHA) proposals around member enrollment for CCO 2.0. Legacy Health is the largest nonprofit, community-owned health system serving the Portland-Vancouver and mid-Willamette Valley areas. Our mission is to create a legacy of health for our people, our patients, our community and our world. We are committed to ensuring every Oregonian has access to quality, integrated care, which starts with an established primary care relationship.

Legacy supports honoring member choice through an open enrollment process, but it is important also to prioritize the established primary care provider relationship. We believe that OHA should make it easy for members to stay connected to their existing primary care provider whether in open enrollment or through OHA assignment in CCO 2.0. We are concerned that the enrollment options proposed by OHA focus on existing CCO relationships rather than provider relationships.

Legacy, the state, and other health systems have invested considerable resources over many years to build a strong primary care system based on the Patient Centered Primary Care Home model. Through established relationships with primary care providers and care coordination, we have made progress in disease management, prevention and reducing unnecessary emergency visits.

We encourage OHA to design an enrollment process that ensures members can choose a CCO that keeps their established primary care provider and ensures that members understand how their choice of CCO impacts their existing primary care provider relationship. Additionally, if the member does not choose a CCO during open enrollment, the state should prioritize the members primary care provider relationship when assigning them to a CCO to ensure continuity of care. Ensuring continuity of care will ensure better health and avoid unnecessary cost.

Sincerely,

Kathryn Correia
President and Chief Executive Officer

Metropolitan
Pediatrics, L.L.C.

November 26, 2018

Dear Director Allen and Mr. Vandehey,

I am writing on behalf of Metropolitan Pediatrics, a group of 38 pediatric providers that provide Primary Care and Behavioral Health Services to nearly 40,000 Oregon children in the Portland metropolitan area. I'm excited and wish to express my sincere appreciation and gratitude to the Oregon Health Authority (OHA) for the thoughtful approach to the CC0 2.0 model and priorities, especially to the very specific intent of highlighting the needs of children throughout this process.

With respect to children specifically, I would like to highlight some considerations that I feel are vital to ensuring the continued progress in promoting optimal health for the children in Oregon. Your consideration of social determinants of health as well as examining how to improve efficiencies and return on investments in health care delivery are all very important when looking at all populations, including children; however, how one would measure these priorities in children can often be very different than how one might approach these priorities with adults. Many of the traditional risk adjustment and rate setting methodologies used in health care do not prioritize children and do not consider the potential unintended consequences that may occur in child populations. Health care services we provide children are most importantly preventive, and the return on investment is often seen as they become part of adult population. There are children with high medical needs and/or behavioral health care needs, and the focus in these areas is also critical; but, even in children with medical/behavioral complexity, the significant return on investment is often seen in other sectors and in adulthood. It is now well understood that Kindergarten readiness is a true marker of success for long term health and success in adulthood. Truly valuing and committing to this investment in young children is critical to the future of Oregonians.

Rate setting and risk adjusting processes that are largely diagnosis and disease driven do not correlate to the challenges and needs of children. Children develop over time and their diagnosis and/or chronic diseases develop over time. It is critical that we pay for services to prevent and curve the impact of risks associated with development of these processes. The Oregon Health Plan is largely a diagnosis driven system. We do value preventative care in the process, but when a child has an early onset behavioral problem or developmental delay, services are often delayed for years because the child does not have a "qualifying" diagnosis, as well as the fact that we have a shortage of services for the population and that there are significant challenges in those affected receiving needed services. The complexity of the pediatric population is underrepresented due to the fact that diagnoses that represent evolving chronic diseases and/or risks for that evolution are not "counted" in our diagnosis-based risk adjustment methodologies or rate setting methodologies that depend upon services historically delivered to a population.

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www.metropediatrics.com

Metropolitan
Pediatrics, L.L.C.

I strongly encourage OHA to consider having rate groups that completely separate children from adults. Most of our rate groups are separate, but the Blind and Disabled group should also be separated. This will allow us to use innovative approaches to rate setting and risk adjustment that acknowledge the unique differences between children and adults. There is very progressive work currently occurring with OHA and the Oregon Pediatric Improvement Partnership which will use the most current stratification techniques in children as well as innovative processes looking at the social determinants of health in children. I do not believe that we currently have adequate solutions for how to value the necessary care for children "at risk" of certain diseases and conditions, but having all children 0-18 in a separate rate categories will allow us to move forward in using this work to better understand how we should set rates for children's health care, as well as risk adjust those categories.

Oregon is a leader in ensuring health care for all children. In 2009, the Oregon legislature voted to provide health care for most children in Oregon. In 2012, we voted to insure almost 50% of our children through Medicaid with the plan to have all children in families up to 300% FPL be eligible for the Oregon Health Plan. In 2018, we voted to insure all children, regardless of immigration status, with the Oregon Health Plan. With these decisions come great pride and great responsibility. Oregon Health Plan for children is much more than a "safety net". It is the program we have chosen for most of our children. We need to separate children from the traditional methods of health care risk adjustment and rate setting for adults so that as we continue the evolution of valuing our investments in our youngest Oregonians, we can invest in our children's future in ways that will be appropriate and wise.

Sincerely,

Resa Bradeen MD

Resa Bradeen MD
Chief Medical Officer
Metropolitan Pediatrics, LLC

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Multnomah County

November 19, 2018

Patrick Allen, Director
Oregon Health Authority
500 Summer St. NE
Salem, OR 97301

Director Allen,

As the state's largest Federally-Qualified Health Center (FQHC), Multnomah County provides direct clinical services through seven primary care clinics, six integrated dental clinics, one specialty HIV clinic, ten school-based health clinics, and seven pharmacies.

Multnomah County's Community Health Centers provided comprehensive, high-quality primary care to over 66,000 unique clients in 2017. Our clinics are recognized by OHA for their commitment to patient-centered care and qualify as Patient-Centered Primary Care Homes.

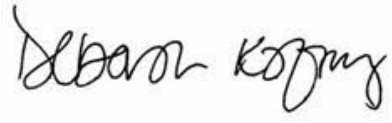
In reviewing the proposed open enrollment scenarios, we believe that OHA's decision should rely on two guiding principles: patient choice and continuity of care. First, OHP members should be given the option to choose the CCO in their region that works best for them. Second, OHP members should be allowed to keep their current primary care provider.

The scenarios presented in the "Public Input Session CCO 2.0 Member Enrollment" document posted on the CCO 2.0 website make little mention of ensuring that OHP members stay with their current provider. The scenarios appear to function as ways for CCOs to either retain or gain membership, rather than centering patient experience and continuity of care.

As outlined in ORS 414.647, currently the transfer of members from one CCO to another is predicated upon either a member's choice to transfer or upon a member's provider moving to a new CCO. The member follows the provider unless they decide otherwise. We believe this is a balanced approach that promotes continuous access to care as the default, while still ensuring member choice.

We encourage OHA to support an open enrollment process that maintains this balance, giving the member choice, but also recognizing the importance of continuity of care over CCO enrollment numbers.

Thank you,



Chair
Multnomah County

Commissioner, District 1
Multnomah County

November 28, 2018

Zeke Smith, Chair
Oregon Health Policy Board

Patrick Allen, Director
Oregon Health Authority

OCCYSHN
Oregon Center for Children and Youth with Special Health Needs

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Portland, OR 97239

Dear Mr. Smith, Mr. Allen, and Members of the Oregon Health Policy Board:

The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) is Oregon's Title V public health agency for children and youth with special health care needs (CYSHCN). Our center works to improve the health, development, and well-being of Oregon's CYSHCN population.

Children and youth with special health care needs are those "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally."[1] About one in five Oregon children has a special health care need. Recent estimates suggest that more than one-third of Oregon CYSHCN under the age of 18 have public health insurance.[2]

Because CYSHCN will become adults with disabilities and chronic conditions, we appreciate the opportunity to provide comment on CCO 2.0 Member Enrollment and CCO 2.0 Rates and Risk Adjustment for the Oregon Health Authority's forthcoming contracts with Coordinated Care Coordination Organizations. Regarding member enrollment, we offer the following four considerations.

1. Continuity of care is critical to CYSHCN and their families. Methods for members who fail to make a CCO selection within the designated timeframe should ensure continuity of care not only between CYSHCN and their primary and specialty medical care providers, but also with their current behavioral/mental, oral health, and allied healthcare providers. This may necessitate the use of claims data to identify services used within a multiyear lookback period.
2. Ensuring flexibility in enrollment periods, and minimizing disruptions in coverage through longer enrollment duration, would help to ensure that CYSHCN and their families select the CCO that best meets their needs, which may include the ability to change their selection after attempting to access services. We echo the recommendation of the Children's Health Alliance that families should be allowed to change CCOs at least once per calendar year.
3. Frequent and timely communication with, and education of, families of CYSHCN about the enrollment process will contribute to ensuring continuity of

[1] McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P.W., et al. (1998). A new definition of children with special health care needs. *Pediatrics, 102*(1), 137-140.
[2] http://childhealthdata.org/browse/survey/results?q=4828&r=39

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care. Educational materials disseminated to families must be culturally and linguistically understandable and appealing. OCCYSHN and the Oregon Family to Family Health Information Center (OR F2F HIC) have extensive experience preparing and reviewing similar materials and will gladly partner with OHA to review materials for family-friendly content and tone. Additionally, OR F2F HIC has relationships with more than two dozen key statewide parent organizations, and regularly hosts educational events across the state with families of CYSHCN about insurance and other health care topics. OCCYSHN can help OHA disseminate information to families of CYSHCN about CCO changes.

4. Should continuity of care be disrupted because of auto-assignment, the establishment of a time-limited pediatric customer service priority line would speed resolution of misplacements.

We also appreciate the opportunity to comment on CCO 2.0 Rates and Risk Adjustment. For the reasons articulated by the Children's Health Alliance, which we will not repeat here, we advocate for separation of the pediatric population from the adult population. Examining the risk adjustment methods used within the pediatric population will be particularly important for CYSHCN and the plans insuring them, because health care costs for CYSHCN are higher than costs for children and youth without special health care needs.

> *Data from the Medical Expenditure Panel Survey (MEPS) show that the cost of health care services for children without special health care needs averages $717/year; while health care costs for CYSHCN average $2,399/year (Bethell, 2011). Thus, we can imagine how a health plan that enrolls a disproportionate number of CYSHCN might suffer financially if they were paid an average unadjusted rate based on the costs of the many children using $717/year and the costs of a few children using $2,399.*[3]

Additionally, children and youth who are more complex, in that they meet four of the five screening criteria to be identified as having a special health care need,[4] have much higher costs than CYSHCN typically; $7,881/year versus $2,399/year.[3] Results of analyses using 2000-2007 data from Washington state and New York showed that average annual cost for children's care was $1,000. The 80% of children without chronic conditions averaged $600 annually; however, when children were categorized into the following condition groups, extreme variation in cost was observed.

- *Episodic chronic conditions (such as asthma), that last at least one year and are highly variable, but that can improve with treatment.* $2,000 per year

[3] Tobias, C., Comeau, M., Bachman, S., & Honberg, L. (2012). *Risk adjustment and other financial protections for children and youth with special health care needs in our evolving health care system.* Retrieved from http://cahpp.org/wp-content/uploads/2015/04/risk-adjustment.pdf. Page 5.

[4] Criteria: (1) Limited or prevented in ability to function, (2) Prescription medication need or use, (3) Occupation, physical, or speech therapy need, (4) More than routine use of medical care, mental health care, or other health services, and (5) Counseling or treatment need for an ongoing behavioral, developmental, or emotional condition for at least 12 months.

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- *Lifelong chronic conditions that are typically stable, such as type 1 diabetes.* $10,000 per year
- *Complex chronic conditions in two or more body systems or conditions that have shortened life expectancy, such as cystic fibrosis, muscular dystrophy, and cerebral palsy with encephalopathy.* $27,000 per year
- *Malignancies, the highest cost category, but with more predictable costs due to protocols.* $75,000 per year[5]

Thus it is easy to see how a health plan that includes the pediatric cancer center and one or two physicians in the community who see children with cystic fibrosis could be financially at risk for becoming insolvent if they only received an unadjusted capitation rate of $1,000/year for all children.[5]

We request that OHPB and OHA study the validity of using pediatric models of chronic condition identification, such as the Pediatric Medical Complexity Algorithm (PMCA), to identify risk within the pediatric population and to consider how the Prometheus Analytics approach to episodes of care supports health care settings in providing necessary care to CYSHCN. We have been using the PMCA in our own work to examine costs of care for children served in Oregon Patient-Centered Primary Care Homes. Given our expertise with the CYSHCN population, we also would be happy to collaborate with OHA to consider thoughtfully risk stratification methods for the pediatric population and potential payment approaches.

We are profoundly grateful for the Oregon Health Policy Board and Oregon Health Authority's extensive effort to obtain public input for the next round of CCO contracts. Thank you for considering our recommendations on behalf of Oregon's CYSHCN and their families. Please let us know if we can provide any additional information.

Sincerely,
Benjamin Hoffman, MD, Director
Sasha Ansari, BS, Development and Implementation Support Coordinator
Tamara Bakewell, MA, Family Involvement Manager, OR F2F HIC Director
Marilyn Berardinelli, BS, Development and Implementation Manager
Lydia Dennehy, BS, BA, Parent Partner
Gillian Freney, BA, Communications Coordinator and Zetosch Fund Coordinator
Sheryl Gallarde-Kim, MSc, Assessment & Evaluation Research Associate
Alison Martin, PhD, Assessment & Evaluation Manager
Robert Nickel, MD, Medical Consultant
Colleen Rawson, MSc, Development and Implementation Specialist
Charlotte Schley, Administrative Coordinator
Shauna Signorini, BS, OR F2F HIC Family Trainer
Brittany Tagliaferro-Lucas, Administrative Program Manager
Jenna Toney, MSW, Development and Implementation Associate

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[5] Tobias, C., Comeau, M., Bachman, S., & Honberg, L. (2012). *Risk adjustment and other financial protections for children and youth with special health care needs in our evolving health care system.* Retrieved from http://cahpp.org/wp-content/uploads/2015/04/risk-adjustment.pdf. Page 6.

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November 28, 2018

Oregon Health Authority
Attn: Director Patrick Allen and Jeremy Vandehey
CCO2.0@dhsoha.state.or.us

RE: Public Comment – Rates and Risk Adjustment/Member Enrollment—November 19, 2018 Meeting

Dear Director Allen and Mr. Vandehey:

Thank you for the opportunity to respond to the proposals about CCO 2.0 rates, risk adjustment, and member enrollment shared with the public on November 19. We set forth below our feedback on proposals offered by the Oregon Health Authority. We've divided our feedback into sections, consistent with various proposals.

Rates

Statewide Rates with Area Factors and Updates Every Two Years

Each CCO is responsible to ensure that its members receive covered benefits. Given that rates are not certified at the CCO level for actuarial soundness, we are concerned that rates set at the statewide level may not be adequate. Each CCO's base data makes up a much smaller percentage of the statewide total than the regional total. This dilutes the predictive power of the data relative to any given CCO and places even more importance on adjustment factors, how those factors are applied (or not applied, as is the case for several rate categories regarding risk adjustment), and whether those factors produce an adequate rate. While we generally support the predictability of rates set on a two-year basis, we observe that moving to a two-year schedule for updates places more significance on the trend assumptions used by the OHA to generate rates. We are concerned about the risk CCOs will incur, particularly when this risk is combined with historic rate-setting experience that indicates rates will generally be set at or near the lowest bound of actuarial soundness. We would like to learn more about how the OHA proposes to address these risks, and if the OHA elects to convene more discussions about these proposals, we would be pleased to participate in a workgroup with actuarial and risk adjustment subject matter experts.

Removing Inefficiency from Base Data

We agree that CCOs should be motivated and incentivized to remove inefficiencies, but we think this priority must be paired with an analysis of the achievability of changing the low-value care—and whether expectations about changes meet the requirements for actuarially sound rates. We hope that these efforts are integrated into broader value based payment efforts. Please see our comments, below, regarding "encounter only" models.

Spending SDoH Pool "Wisely"

We would like to learn more about what the OHA means by the statement that CCOs will be "rewarded for their efficiency" in "spend[ing] their SDOH pool wisely." How will this be measured? We believe that each CCO should make investments in social determinants of health (SDoH) consistent with the community health assessment and health improvement plan. This should result in variation region-by-region. What standards will the OHA require to demonstrate wise spending? It's helpful to know these standards well in advance of any effective date because it takes time to mobilize the community to stand up a new, transparent process or to modify existing processes.

Risk Adjustment

Given the general nature of the risk-adjustment proposals, it is difficult for us to provide specific comment with concrete suggestions. If the OHA elects to convene more discussions about these proposals, we would be pleased to participate in a workgroup with actuarial and risk adjustment subject matter experts. We think it's essential to align risk adjustment and quality initiatives.

Encounter Data Risk Corridor

We are concerned that if the OHA reviews encounter data expenses only, many essential costs will not be captured. Many value-based payments would not be counted under this method. This approach seems inconsistent with the OHA's approach to rate setting for 2019 rates, including the rationale referencing a specific category of payments within the HCP-LAN framework. Indeed, for value-based payment arrangements operating in capitation or blended payment models, this type of risk corridor would represent a substantial disconnect between the value-based payment road map, existing rate-setting strategies, and the overarching intent of CCO 2.0. We strongly encourage the OHA to be consistent in its approach to value-based payment and to avoid adopting strategies for rate setting or risk corridors that conflict with shared priorities to promote efficiency and additional value-based payments.

In the event the OHA issues a requirement that CCOs report fee-for-service equivalent amounts for value-based payments, it will be important for CCOs to understand how those equivalent values will be set and using what rate scale. Without clear information in advance of the risk corridor period, we would have many of the same concerns here about disincentives and rate slides associated with value-based payment arrangements consistent with the value-based payment road map and the HCP-LAN framework that we articulated above.

We also request clarity from the OHA to understand which dates of service will be used in the risk-adjustment process and how risk adjustment information will be shared by the OHA with each CCO where a member is new to the CCO but not new to the OHA.

Risk Adjustment for SDoH/Health-Based Risk Adjustment

We would like to learn more about how the OHA will risk adjust CCO capitation rates based on SDoH. If this risk adjustment will be at the member level, we are concerned that significant data collection efforts will be required. It would be helpful if the CCOs could participate in that process. In the event the OHA pursues retroactive risk adjustment, it will be important for CCOs to understand how the OHA is managing the risk score process so that CCOs can accrue funds appropriately. We would also like to understand how churn or long delays in processing member applications may impact risk adjustment.

We also believe that encounter data should not be the sole source of information for health-based risk adjustment. Best practice would suggest that there needs to be an avenue for CCOs to submit supplemental diagnostic data, so long as the data are well documented and supported.

Member Enrollment

Values and Priorities

We agree that there should be minimal disruption of members' continuity of care and that it is essential for the OHA to honor member choice. Financial viability thresholds may vary from CCO to CCO.

Auto-Assignment Approach #1

Newly formed CCOs are unlikely to be viable if they rely solely on newly eligible members for enrollment. This approach is also particularly dependent on the OHA's processes to timely enroll new applicants for OHP coverage. We support family and Medicare Advantage alignment.

Auto-Assignment Approach #2

We support family and Medicare Advantage alignment.

Auto-Assignment Approach #3

Without more information about each scenario that would qualify as "restructuring" or how that would be evaluated, it is difficult for us to provide comment on this approach.

Thank you for your time and consideration. We appreciate the opportunity to provide public comment and to participate in this transparent CCO 2.0 process in service to our members and communities.

Sincerely,

Lindsey J. Hopper
Vice President, Medicaid Programs
PacificSource
Lindsey.hopper@pacificsource.com

Providence Health & Services
4400 N.E. Halsey St., Building 2
Suite 599
Portland, OR 97213
www.providence.org/oregon

Date: November 28, 2018

To: Patrick Allen, Director, Oregon Health Authority
Delivered via email to CCO2.0@state.or.us

From: Jon Cascino, Medicaid Program Director, Providence Health Plan

RE: CCO 2.0 enrollment and rates

Dear Director Allen:

Thank you for the opportunity to comment on the Oregon Health Authority's proposals regarding member enrollment and rates and risk adjustment in CCO 2.0.

OHA CCO 2.0 Member Enrollment Comments

The Oregon Health Authority has stated previously and reiterated at the November 19th meeting that ensuring continuity of care of OHP beneficiaries is the most important consideration guiding OHA's decisions related to membership enrollment in CCO 2.0.

Providence Health & Services agrees with this policy principle. January 1, 2020 (the contract start date for CCO 2.0 contracts) will be an important date for OHA and the CCOs; however it is an arbitrary date for beneficiaries. As we have learned through other CCO transitions, true continuity of care means that OHP beneficiaries should be able to see the same primary care provider and/or same specialists after January 1 as they do before January 1. This would also apply to an individual's ability to use referrals that happened in December for appointments with specialists in January, and refill existing prescriptions to maintain medication adherence. Providers should anticipate the same referral processes, authorization criteria, provider representative contacts, claims submission processes, and other critical core functions needed to serve OHP beneficiaries after January 1 as they do before January 1. Policies that encourage this continuity should be chosen over policies that have the potential to disrupt care.

OHA outlined three approaches to member auto-assignment with approach #1 and #3 designed with continuity of care as the primary consideration.
In our view, achieving continuity of care will require understanding the structure of each CCO and what, if any, structural changes have occurred. If a delegated health plan serving OHP beneficiaries decides to participate in a different CCO or applies to be a CCO, those OHP beneficiaries should be auto-assigned to that new CCO to maintain continuity of care. Looking into a CCO to determine the appropriate level of assignment will be an administrative challenge for OHA, but spending that effort in preparation of January 1, 2020 will ensure OHP beneficiaries experience minimal disruption.

OHA CCO 2.0 Rates and Risk Adjustment Comments

Statewide rates with area factors
We generally support the concept of the proposal, but urge OHA to be transparent in how area factors are developed. We also support a statewide reinsurance pool as a way to mitigate risk.

Rebasing every two years
While this proposal offers OHA and the CCOs the opportunity to focus on analysis in off-cycle years, instead of directing all resources toward rate development, we are concerned about the potential impact on the ability to identify and mitigate emerging systemic cost drivers. For example, for 2019 rates, OHA identified changes in membership due to the renewals process, pharmacy costs and fluctuations in rural hospital costs as primary drivers. Previously, OHA identified Hepatitis C drug costs. Going through the formal rate setting process each year allows OHA the opportunity to identify and act on these types of cost drivers.

Removing inefficiency
OHA is proposing using Prometheus Analytics to adjust statewide base data for potentially avoidable costs. Prometheus is a software tool owned by a private company – Altarum. OHA has made transparency a major tenant of CCO 2.0. The use of a private tool to make adjustments to statewide base data raises considerable transparency issues. At a minimum, CCOs should have the ability to see performance during the base year as opposed to retroactively. We also encourage OHA to respond to the following questions prior to the RFA:

- Will OHA make Prometheus available to all CCOs to use?
- Will OHA issue reports during the base year for CCOs to analyze and react to?
- Will OHA issue CCO-level reports for rate setting? For 2020 rates, is OHA going to apply Prometheus to 2018 data?

We have strong concern that the use of Prometheus will effectively create a “black box” which is counter to both transparency and the smart use of analytics for CCOs and other stakeholders.

Risk adjustment for 2020 rates
OHA proposed two approaches to risk adjusting initial 2020 rates: (1) setting an encounter data risk corridor; and (2) retroactive adjustment. The encounter data risk corridor option is concerning. First, the risk corridor concept has winners and losers unnecessarily. A CCO with a low-risk population relatively has an artificial advantage over a CCO with a high-risk population due to the 98/102% risk corridor. Additionally, because OHA will review encounter data expenses only, a CCO with fee-for-service reimbursement has an advantage over a CCO with value-based purchasing arrangements, which runs contrary to a primary objective of CCO 2.0. Finally, a CCO with costs outside the corridor has no limit on downside loss or upside gain as OHA is only committing to pay for, or seeking reimbursement of, “a percentage” of the costs outside of the corridor. We would encourage OHA to explore other options.

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November 28, 2018

Patrick Allen
Director
Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

Delivered via email to CCO2.0@dhsoha.state.or.us

Dear Director Allen:

On behalf of Randall Children's Hospital and our pediatric primary care clinic, Randall Children's Pediatric Care – Emanuel, thank you for the opportunity to comment on the rate setting and risk adjustment methodology used by the Oregon Health Authority (OHA) to address differences in health-based disease burden between Coordinated Care Organizations (CCO's).

We have concerns with the OHA methodology as it applies to the pediatric population. OHA uses both demographic factors and an assessment of disease burden based on the Chronic Illness & Disability Payment System (CDPS-RX) to risk assess and stratify CCO's. The CDPS – RX tool was originally developed for risk stratification in Medicare populations and does not account for the unique medical diagnoses of pediatric populations. It also does not capture the mental health disease burden or the social determinants of health that affect pediatric populations so profoundly.

Fifty percent of Oregon children receive their healthcare coverage through Medicaid. However, using the CDPS-RX underestimates the relative contribution of pediatric patients to the total disease burden of each of the CCO's. This risks under supporting CCO's that have a larger burden of disease represented by pediatric populations. An example would be the Portland Metropolitan area which has the only freestanding pediatric hospitals in the state and therefore sees a larger volume of children with complex medical needs. This under support is multiplied at the local level as the various CCO's and Risk Assuming Entities (RAE's) use the same OHA data in their risk assessment strategies leading to a smaller and smaller slice of the pie being apportioned to pediatric populations. This has led to the current situation in the Portland Metropolitan area where all pediatric offices with large Medicaid populations are now risk assessed at the lowest level compared to adult offices and are subsequently underfunded in their efforts to serve the most vulnerable patients.

An alternative risk assessment tool that better measures pediatric disease burden has been developed and used in risk stratification (see reference).[1] We request that OHA consider using the Pediatric Medical Complexity Algorithm (PMCA) in their efforts to match payment to risk for the individual CCO's in order to more accurately measure the pediatric contribution to total disease burden of Medicaid populations.

Thank you for your consideration.

Sincerely,

Bronwyn Houston, MHA, MA
President
Randall Children's Hospital
at Legacy Emanuel

Brad Olson, MD, MS
Medical Director
Randall Children's Pediatric Care – Emanuel

[1] Pediatric Medical Complexity Algorithm: A New Method to Stratify Children by Medical Complexity. Simon TD, Cawthon LM, Stanford S, Popalisky J, Lyons D, Woodcox P, Mangione-Smith R. *Pediatrics.* 133;6. 2014. Pp.1647-54.

Teresa Alonso León
State Representative
Oregon House District 22

November 19, 2018

Director Pat Allen
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301

Dear Director Allen,

Thank you for taking time to hear from the public about the enrollment process for CCO 2.0.

As the State Representative for House District 22, a district serviced by multiple Coordinated Care Organizations and the only district in the state that is home to a majority of people of color, this process directly affects my constituents in a unique way.

Keeping my constituents in mind, I believe that anytime that there is a proposed transition of care, we should pause to ensure it is done in the most equitable, culturally competent way possible with our main focus being the patient's access to care and continued wellbeing.

CCOs have become a part of the fabric of the communities that they serve, each one creating programs unique to the needs of their members. As we know, many in the Medicaid population do not feel empowered or that they have the tools they need to engage with the healthcare community on a regular basis and CCOs have formed programs specific to the areas that they serve. To force members to rebuild those relationships would be an incredibly arduous task, and I would fear that some of my constituents would be at risk for falling through the cracks. Furthermore, the process of completing eligibility paperwork often feels inaccessible for many Oregonians, especially if that enrollment process is different from what they have already become accustomed.

Finally, I believe it is critical to remember that there are disparities in broadband access for rural communities, communities of color, and low-income communities. With the majority of enrollment happening online, these communities would have to work even harder to access their health needs, enrollment benefits, and eligibility paperwork.

I would ask you to consider, as you look at the enrollment process for CCO 2.0, to allow currently enrolled members to default to stay within their existing CCO. Should there be an instance where a member chooses to receive care through a different CCO, then I believe we should allow them to do so freely.

I want to thank you for the critical work you and your agency staff have done to move Oregon in ensuring that all of our residents have quality and accessible healthcare. Your commitment to this work does not go unnoticed.

Thank you for your consideration. Please do not hesitate to reach out to my office with any additional questions at 503-986-1422 or Rep.TeresaAlonsoLeon@oregonlegislature.gov

Sincerely,

Teresa Alonso León
Oregon House of Representatives
House District 22