John A. Kitzhaber, M.D.
Oregon Governor
1995-2003; 2011-2015

September 8, 2019

The Honorable Kate Brown
The Honorable Peter Courtney
The Honorable Tina Kotek
Oregon State Capitol
900 Court Street, NE
Salem, Oregon 97301

Dear Governor Brown, President Courtney, and Speaker Kotek:

Let me begin by thanking you for your legislative and executive leadership over the past four years to ensure the health and welfare of the people of our state. Your work in closing the funding gap in the state health budget, helping more Oregonians gain access to mental health and addiction services, expanding access to intensive, in-home behavioral services for children, and your landmark work in affordable housing are great steps forward for our state. I am writing to call to your attention two issues which could potentially undermine this extraordinary progress toward expanding access to quality, affordable health care to all Oregonians.

The first and most important issue involves the policy objective driving the "CCO 2.0" process — specifically, whether the State of Oregon remains committed to the local, collaborative, community-based model that drove the creation of CCOs in 2012, or whether a decision has been made to move in another direction. As you know, CCOs emerged from the Great Recession when our state faced a $1.2 billion shortfall in the Medicaid budget and at a time when unemployment was increasing and thousands of Oregonians were losing their workplace-based health insurance.

It soon became clear that without replacement revenue, tens of thousands of Oregonians would lose access to needed medical care, and/or providers would face a reimbursement cut of nearly 40%, creating other barriers to access. Instead of perpetuating the traditional "MCO" model by adopting these cost-shifting strategies, our state came together around an approach focused on expanding access <u>and</u> managing cost by <u>transforming the care model</u> to get more value for each dollar spent.

This transformation would be achieved by creating a new kind of organization through a <u>partnership</u> between payers, local providers and local citizens and with a local governance structure. CCOs would strive to move beyond the narrow clinical model to a larger focus on community health by emphasizing local collaboration, innovation and community engagement rather than top down regulation. Furthermore, they would assume both upside and downside risk for the health of the population within the context of a global budget indexed to a sustainable growth rate of 3.4% per member per year. Thus, the CCO care model was built around five specific components:

1. Local accountability and governance
2. A global budget with a fixed rate of per capita growth
3. Integrated and coordinated care
4. At risk for quality (metrics)
5. Flexibility

Over the course of its first five-year waiver period, the CCOs made remarkable progress towards this vision. The state operated within the 3.4% per member per year growth rate and realized a cumulative total funds savings of over $1 billion. All CCO's met the quality and outcome metrics stipulated by the waiver while enrolling an additional 360,000 people under the ACA expansion.

Certainly, significant challenges remain. Some CCOs have performed better than others, there is regional variation in per capita cost growth, and all CCOs have room for improvement in terms of behavioral health integration and effectively investing in the social determinants of health. Nonetheless, system transformation takes time. We have made significant progress toward this vision and now have the opportunity to build on our success to date. The question is whether we seize this opportunity and double-down on our commitment to community-based delivery system transformation; or whether we have decided to refocus our policy in another direction.

The contours of CCO 2.0, as they emerge from the current procurement and contracting process, appear to reflect a decision to move away from a flexible, community-based, collaborative model toward a commercial insurance model with more focus on regulation. This shift threatens to undermine the effort to transform health care delivery by embracing many of the attributes of the traditional rate-based insurance system we have been trying to escape.

For example, under the new approach, all CCO's must now comply with NAIC reporting requirements, which were established to provide regulatory oversight of the insurance industry, not for the kind of community-based model reflected by the CCOs. Furthermore, most of the new financial administrative rules with which CCOs will have to comply appear to have been "copied and pasted" from the current insurance code. My understanding is that DCBS will be acting on behalf of the OHA for financial oversight, which is significant. In addition, the contracts now include numerous financial fines and penalties and give OHA broad flexibility over how to issue those sanctions.

These provisions and others appear to retreat from the community model based on local control and a sense of local "ownership" in favor of a more punitive top down approach. To comply with this significant increase in regulation and reporting requirements, CCOs will have to hire additional personnel and, in some cases, purchase new software, without new resources with which to do so. This, in turn, will increase administrative costs and undermine the resources available to invest in further delivery system transformation and in the social determinants of health, two fundamental cornerstones of CCO 2.0.

Many of the new administrative rules are very prescriptive around the care delivery areas for which the CCOs must develop value-based payments, around the definition of the "prioritized populations" that will be eligible for intensive care coordination services, around the proposed 15:1 ratio of members to care managers and the reporting timeframes. In many cases, these requirements would be difficult, if not impossible, to comply with, and in some cases, will be

extraordinarily expensive. The question is, do these new requirements actually help deliver better, more cost-effective care to Oregonians?

I am concerned that this increase in rules, regulations and reporting will be particularly burdensome on smaller rural CCOs which have become important community assets. These CCOs have been making significant local investments in the social determinants of health, in early learning and in clinical innovation. In short, this new policy direction appears to shift the focus of the CCOs from a trusting, collaborative relationship with the local community to a much more rigid, regulatory and potentially confrontational relationship with the state.

Lastly, some supporters of these additional regulations on the CCOs argue it is necessary for providing more fiscal oversight and transparency. As the transformation of the care model continues to evolve, I understand and support the need for improving fiscal oversight and transparency for CCOs. However, I am convinced this goal can and should be accomplished without losing local flexibility, compromising community engagement or narrowing the space for innovation and delivery system transformation – core elements contributing to Oregon's success to date.

The second issue involves the efforts by Trillium (owned by Centene) to establish itself in the Portland metropolitan area. If viewed strictly through the lens of a publicly traded commercial insurance company seeking to increase its "market share" in Oregon, this may make some sense. If viewed through the lens of a community-based collaborative model, one committed to transforming care for our most vulnerable people, it makes less sense.

First, there is significant resistance to Centene's effort to expand into the metropolitan area. This resistance comes from several sources, including a number of metro area hospitals which have been working for the past year to build local consensus around how to restructure Health Share of Oregon to best meet the needs of the Medicaid population. There is also resistance from the three metro counties. Without strong ties to and support from metro counties, health systems and providers, it is difficult to see how this commercial insurance company, headquartered in Missouri, can truly develop and demonstrate the community relationships and engagement that are central to the whole concept of the CCO model.

The Medicaid population in the Portland metropolitan area includes some of the state's most vulnerable people who are now in a stable and well-run health plan after the disruption caused by the closure of Family Care. Furthermore, when Health Share was only managing a part of the population (and the part with greater needs) it was unable to operate within the 3.4% per member per year growth cap. Since it began managing the entire population, however, it is now operating under the growth cap at a rate of 3.38%.

If Centene meets the readiness review, the proposed attribution process runs the risk of disrupting care relationships and associations to the detriment of care continuity for some very vulnerable people. In addition, it is my understanding that member contact with a nurse or through an e-visit or via phone will not count when determining if a member is "engaged." This ignores the fact that, in some cases, these may be healthy people who are being well managed — the goal of the CCO model in the first place.

Finally, the effort to establish Centene in the Portland metropolitan area has been justified on the basis of "market competition." Yet there is little evidence that such competition in the CCO framework of a global budget and quality standards and incentives produces better outcomes.

If the goals of CCOs are to manage the health of the population within a global budget indexed to a sustainable growth rate, and to invest in the social determinants of health through strong community support and engagement, bringing Centene into the metro market would appear to contradict these goals.

In conclusion, it is my view that the two issues I have outlined above reflect a deviation from legislatively adopted policies, and may have serious unintended consequences to the health care transformation efforts that I know we all support. OHA has a series of incremental administrative actions scheduled throughout the next six months which will solidify and reinforce these new policies into the future. Before that happens, I encourage you to consider the potentially negative impacts of this shift in policy and whether or not it is the best way to advance our goal of ensuring every Oregonian has access to quality, affordable health care.

Sincerely,

John A. Kitzhaber, M.D.
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cc: Senator Laurie Monnes Anderson, Chair, Senate Health Care Committee
Rep. Andrea Salinas, Chair, House Health Care Committee