To: Senate Health Care, Human Services
and Rural Health Policy Committee

From: Health Care Action Team
Metropolitan Alliance for Common Good

## Re: SB 1580

Date: February 3, 2012

**Our request:** Adopt SB 1580, with an amendment to the CCO governance provisions.

The Metropolitan Alliance for Common Good is a broad-based organization of 20 religious congregations, labor union locals and community-based organizations in the Portland Metro area.

We have made health care reform a high priority since 2003, when our member institutions began hearing that access, equity, quality and cost of health care were the major concern of their individual members. Some of our members were involved earlier in the establishment of the Oregon Prescription Drug Program. We have been part of the recruitment efforts for the Healthy Kids program since the passage of HB 2009 in 2009.

One of MACG's major goals is to represent people who do not have lobbyists working on their behalf either at the legislature or at state agency proceedings. We have a particular interest in making sure that the voices of low-income consumers of health care are heard in the conversations about reform.

We have been part of the public process used by the Oregon Health Policy Board and the Oregon Health Authority to develop their CCO Implementation Proposal, pursuant to HB 3650. We appreciate the openness of their process.

Transforming the Oregon Health Plan into a coordinated care delivery system will be complicated. We believe that SB 1580 will give the OHPB and the OHA the authority they need to continue the transformation process.

In December, we held an evening assembly to discuss our thoughts and concerns about the Implementation Proposal with Dr. Goldberg. About 250 people attended. We appreciate Dr. Goldberg taking time to meet with us. One of the concerns was, and is, the lack of clarity in the proposal with regard to governance of CCOs.

We note that HB 3650 provides that each member of a CCO "Must be encouraged to be an *active partner* in directing the member's health care and services and *not a passive recipient* of care." (Section 8(1), emphasis added.)

We think it appropriate that you extend the idea of being an active partner in health care, and not a passive recipient, to the governance of CCOs in Oregon. The community served by a CCO, including low-income and disadvantaged peoples, needs to be an active participant in governing the CCO.

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We realize that OHPB and OHA were somewhat constrained by the terms of HB 3650, Section 4(1)(o), (now ORS 414.625(1)(o)).

Section 4(1)(o) provides that a CCO "governance structure" must be composed of:

(A) A "majority interest" representing the entities that share the financial risks,

(B) The "major components" of the health care delivery system, and

(C) The "community at large". The point of having the community at large is, in the language of Sec. 4(1)(o)(C), "to *ensure* that the organization's decision-making is consistent with the values of the members and the community."

The representative(s) of the "community at large" will be a minority. We suggest that a minority on a governing board is not in a position to *ensure* anything, especially not that the actual decisions of the majority reflect anyone's values.

What the community representative(s) can do is push, poke, and prod the financial representatives and delivery system representatives to engage in transparent decision-making, to be accountable for achieving the triple aim, and to work to understand the health care needs of the people to be served, as those people see their needs.

We appreciate that there is "no single governance solution", but we believe that there should be some reasonable minimums for a governing board. It appears to us that there is only one minimum set in the Implementation Proposal, and it is that at least one member of the Community Advisory Council shall serve on the governing board (Implementation Proposal, pp. 15-16).

If our collective experience with governing boards is any guide, having one member of the community on a governing board will not accomplish much for the "community at large". The human dynamics of being a sole representative on issues makes it difficult to sustain a pushing, poking and prodding stance while maintaining good working relationships with other board members. Not that it can't be done, but none of us would bet on it as a long-term strategy for effective oversight on behalf of the community – or any other interest.

**So our request is simple:** Amend ORS 414.625(1)(o) to provide that each CCO governing board must have at least **one-third** of its members from the "community at large". Asking prospective CCOs to "articulate… How consumers will be represented…" (Implementation Proposal, pp. 15-16) is not sufficient.

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