May 6, 2013

Health Share of Oregon Comments on HB 2020

Members of the Senate Committee on Health and Human Services:

Thank you for the opportunity to express our concerns with HB 2020, which would require CCOs to delegate credentialing authority to all other CCOs in the state for credentialing of mental health and addictions programs. CCOs contract with the State to provide high quality, high value, coordinated care to Oregon Health Plan (OHP) members. Health Share of Oregon is the state's largest CCO, serving approximately 165,000 members in the Tri-County area. Health Share was created through collaboration of 11 existing organizations that serve OHP members and is organized as a private non-profit corporation.

Health Share applauds the effort of Representative Nancy Nathanson and the proponents of this legislation to streamline the credentialing process and reduce administrative burdens for this important group of providers. We agree that credentialing processes can and should be improved; however, we have concerns with the method proposed in HB2020.

We apologize for our failure to communicate our concerns with HB 2020 when the bill was in the House. We hoped to reach a compromise with the proponents of the legislation outside of the committee process but were not able to do so prior to the floor vote. We are confident that we can work out a solution that is agreeable to both parties here in the Senate.

Health Share's concerns with the bill are that it:

1) creates a complex and risky administrative structure for the CCOs to administer,
2) is inconsistent with the centralized provider credentialing process that is envisioned by proponents of SB 604 for physical health providers.

Complex and Risky Administrative Structure for CCOs

This legislation requires the fifteen CCOs to accept the credentialing determination of one CCO. Standard business practices, driven in large part by risk management concerns, means a prudent CCO will not accept the credentialing determination of another entity without entering into a delegated credentialing agreement—whether the state is requiring the organization to accept the credentialing determination or not. Delegated credentialing arrangements require annual audits, stringent oversight and formal contracts clearly delineating roles and responsibilities. That means that each CCO would be audited 14 times and would perform 14 audits for this purpose. Some CCOs would simply refuse to accept the credentialing determination of another CCO and would undertake to credential each program individually. There is also a risk that any particular CCO may not pass the delegated credentialing audit of every CCO, creating an additional layer of complexity for the providers. Some CCOs may choose to limit the number of contracts with these programs, in order to minimize exposure to this onerous credentialing process.

One of the responsibilities in a delegated credentialing arrangement is that the entity who performs the credentialing must keep all contracted entities informed of relevant changes to the provider's demographics, service array, etc. This is particularly onerous to the CCOs and may actually have untoward consequences to the providers themselves if claims are not paid correctly or services are not authorized appropriately because the CCO was not aware of provider changes.

From a public policy perspective, it seems unwise to create a separate credentialing process not only for one type of credentialing organization (CCOs) but for a specific type of provider (mental health and addictions

programs). Health transformation is supposed to reduce silos in the health care payment and delivery system, not entrench them. This legislation would create a small and distinct administrative silo by creating a credentialing process that only applies to one type of mental health provider.

Inconsistent with the Likely Solution for the Same Problem in Physical Health

All health care providers have a persistent and valid complaint about the duplicative and cumbersome credentialing processes required by the health plans, hospitals, and now CCOs with which they contract.

In order to alleviate those concerns, a number of provider groups and credentialing organizations have been working to forge a solution for physical health providers. This solution, as it currently stands, would provide the Oregon Health Authority with the power to develop a system that would streamline the credentialing process so that providers would only have to submit their credentialing information to one organization (overseen by the OHA) and various credentialing organizations would pull credentialing information from that system. This would still permit each credentialing organization to make its own credentialing determinations or to delegate authority to make those credentialing determinations to another organization. It solves the complaint of the providers but does not create additional burden for the credentialing organizations. The legislative vehicle for this is SB 604.

Proposed Solution

We would like to continue to work with the sponsors of the legislation to share information and develop alternative solutions that are efficient and effective for all parties. We are concerned that the sponsors are equating a standard CCO credentialing process with a County Certification process. I believe the latter is much more extensive and intrusive and I believe we can help to make the CCO credentialing process as effective and efficient as possible.

In fact, Health Share has already proposed a potential solution to the providers' concern. This potential solution could address many of the provider concerns without creating an intricate infrastructure of inter-CCO contractual relationships.

We suggest that this body consider enacting legislation that permits CCOs to accept annual state licensure and county certification of these programs in lieu of credentialing until January 1, 2016. We encourage the integration of mental health and addictions providers into the centralized credentialing database envisioned by SB 604. We hope to work out a solution with the proponents of the legislation that looks something like this.

This solution may not address the concerns of all CCOs but it could minimize the burden on the providers for many of the CCOs.

At a time when Oregon has undertaken the formidable task of integrating physical, mental, and oral health, creating dual-track credentialing systems for different parts of the health care system that increases administrative burden on the credentialing organizations is illogical. Rather, the mental health and addictions programs—and individual mental health providers—should be included in the broader conversation of creating a centralized credentialing system.

Respectfully submitted by Janet L. Meyer, Chief Executive Officer

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