Testimony in support of HB 2122, February 27, 2017

Submitted by Charlie Swanson for Health Care for All Oregon-Action & Health Care for All Oregon

Thank you, Chair Mitch Greenlick and members of the committee. I am Charlie Swanson, representing Health Care for All Oregon–Action (HCAO-Action) and Health Care for All Oregon in supporting HB 2122, and in suggesting some modifications for consideration.

The most important purpose of HB 2122 is to strengthen the function of coordinated care organizations (CCO's) as community organizations. Our testimony will begin with describing the importance of the community connection. We will then comment on each section of the bill. We will later include comments about subjects that come up in those discussions.

CCO's as a community organization

HB 3650 (2011), the bill that established CCO's, stated that *"Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two."* Though this phrase uses the permissive "may," there would be no reason whatsoever for this phrase in the bill unless this was meant as an exhaustive list of possibilities. We completely agree with this – CCO's need to have a strong community connection, though a statewide organization with sufficient community governance can work well.

The fact that substantial amounts of public funds are used to finance Medicaid suggests that people think of health care for low-income people as a public good. We agree – in fact, we think healthcare should be thought of as a public good for everyone. It is in many ways similar to education – both healthcare and education definitely help the individual receiving it, but both also help society as a whole in many ways, and both are a big part of a well-functioning society.

In Oregon, the Oregon Health Plan (OHP) is the primary Medicaid program, the other substantial portion being long term care. About 90% of all covered by OHP are in CCO's. In 2015-16, CCO's served over 950,000 Oregonians with an overall budget of at least $4.5 billion. For comparison, k-12 education served somewhat fewer than 600,000 students with a budget of $5.4 billion. So CCO's in Oregon serve more people and have nearly as large a total budget as k-12 education. Oregonians have a strong interest in community control of such an important function with such substantial expenditures of public funds, just as they do for k-12 education.

Regarding this public interest, in a later section we address one of the reasons we think HB 2122 is important – preventing something like the events surrounding the sale of Agate Resources to Centene, which affected Lane County's CCO Trillium.

Comments on sections of HB 2122

Section 1(1) – Membership of the governing board.

The most important part of this is subsection (a), restricting to 25% of the board *"individuals or representatives of entities that share in the financial risk of the organization."* Regarding (b), *"individuals representing the major components of the health care delivery system,"* it may be necessary to specify a range. Provider representation is necessary to ensure that the CCO does not retain too much money for administration and spend too little on the provision of care. We could imagine 25% as a minimum, and the maximum should certainly be less than 50%. There may well be providers with a financial stake in the CCO who would need to be counted in both categories (a) and (b). But some providers not in category (a) may be useful representatives of the community at large – category (c).

Section 1(2) – Open meeting laws.

This is absolutely critical. There is no way that an organization can be reasonably considered a community organization if the community cannot easily find out about and weigh in on decisions. The governing board of all CCO's should be required to follow open meeting laws. This provision needs to be implemented before the next contracting period.

Sections 2 through 5 – Community Escrow Fund

This is also critical. State taxpayers need to own any funds not yet spent on providing healthcare or administrative tasks. The CCO should not own any reserves from the state – they should not be able to abscond with funds or blackmail the state because they have such a large amount of state funds in the event the state contract is not renewed or they do not meet their contractual obligations. Without this safeguard, there is too great a financial temptation for some CCO's to move away from being a community organization.

Section 6 – contracting criteria

This section seems useful. Some metrics are more important than others, and CCO's should have to meet the most important ones. We expect the governor will continue to appoint, and the senate confirm, people with sufficient knowledge and integrity to the Oregon Health Policy Board so that this section can function well.

Section 7 – non-profit

We think it is important for CCO's to become non-profit. Because this will take some time, some of the other provisions in this bill are necessary very soon. Some argue that non-profits often misbehave in manners similar to for-profits, which is true. We discuss why it is still important to move towards non-profits in a section below.

Section 8 – additional conditions

This change seems necessary to allow the other sections to function.

Section 9 – alternative payment methodologies

We are uncomfortable with this section. While it is possible that alternative payment methodologies can more properly align incentives, the available data on this is inconclusive. CCO's are in some sense already an alternative payment system, since they have a global budget – but of course they are, for the most part, not directly a provider. If 100% of a provider's patients were covered by a CCO, alternative payment models would probably be very useful, but when on average only 25% are covered by a CCO, it is not at all clear that an alternative payment model for that small portion is appropriate.

The existing law's encouragement of alternative payment methodologies seems appropriate. Rather than a stiff state requirement, the mix of payment methodologies seems to be the sort of decision best made by providers working together with the community organization that a CCO should be. We could imagine the state creating an incentive for alternative payment models, but a strict requirement seems premature.

Here is an article by the RAND Corporation suggesting that alternative payment models may lead to physician burnout – http://www.pnhp.org/news/2015/march/sgr-fix-apms-threaten-physician-burnout-rand. We can provide, upon request, other references that would suggest caution.

Sections 10 (1) – date for compliance with section 1 of this act

Meeting the requirements of section 1 seems too critical to wait so long. Open meeting laws and a community board should happen much sooner.

Addition regarding change of ownership

There needs to be some review and control when the ownership of a CCO changes. Anytime a transfer of ownership of a CCO occurs it should be reviewed by OHA using existing laws, regulations and input from the CCO Community Advisory Council. Based on this review the OHA can negotiate a new contract with the new owners, if the OHA feels all necessary requirements have been met. Among the most important considerations should be the question about a community organization – will the new ownership structure ensure that the CCO functions as the community organization the legislature envisioned when designing CCO's?

Addition regarding public health

Something like the following should be considered:
"The Board, recognizing that population health outcomes are primarily impacted through attention to the social determinants of health, will direct CCOs to actively pursue interface with the appropriate agencies within the state to address the needs identified in the respective CCO's Community Health Needs Assessment and the Community Health Improvement Plan. The Board shall consider supplemental funding of Public Health Foundational Services if the Board determines that to be the most cost-effective method of carrying out actions deemed necessary to protect and improve population health."

Additions from OHPB recommendations

We think that the Oregon Health Policy Board (OHPB) made some very useful recommendations for CCO reform. Comments in this section refer to the OHPB report – https://www.oregon.gov/oha/OHPB/Documents/OHPB%20CCO%202.0%20RECOMMENDATIONS%20MATRIX%20final.pdf

In general, all of the OHPB recommendations seem useful, except perhaps #12, for which our comments are essentially the same as for section 9 of HB 2122 above. The most important ones for HB 2122 appear to be the following:

#2, Improve CCO Fiscal Transparency, is especially important, and we think it may be useful to put in statute that OHA will develop requirements. We also feel the timeline needs to be before CCO's get their next contract. A community organization needs to be transparent to interested community members.

#3, Improve CCO Accountability – we have essentially the same comment as for #2 above.

#5 seems too weak. A publicly funded community organization should follow public meeting laws.

Why is non-profit important?

Some argue against requiring health care related entities to be non-profit in part because they see non-profits engaging in most of the same sort of misbehavior as for-profits. That is certainly true, but to us it suggests reforming non-profits rather than not requiring non-profit status. For many things that serve a public good using public funds, especially for government protected monopolies or near-monopolies, a profit motive tends to encourage actions that we don't think should be encouraged.

For example, public schools are a near monopoly in their communities in Oregon, and we think running them for-profit would create inappropriate incentives. CCO's are similarly a monopoly in their community – nearly everyone getting state supported health care is enrolled in a CCO. While a well-regulated for-profit can do a good job, there seems to be little reason to suspect they will do better than a non-profit. Certainly for higher education, non-profits seem to help students and society more than for-profits.

Misbehavior by non-profits should be dealt with by enacting better requirements on them. For hospitals, a number of states have substantial requirements, while Oregon has essentially nothing beyond what is required by the IRS and the ACA. This is appropriate for another bill, not for HB 2122.

Excess executive compensation within non-profits should also be dealt with. While CCO's and hospitals are complex organizations and their leaders should be very well compensated, it is not clear that more than 4 times what Oregon's governor makes or substantially more than what the superintendent of Oregon's largest school district makes is necessary. Again, these are not an

appropriate subject for HB 2122, but merely part of the argument against the notion that since non-profits behave in many ways as for-profits, non-profit status is unimportant.

Trillium and the sale of Agate Resources to Centene

We think there are two issues of importance regarding the connection of this sale and this bill. The first relates to the importance of a CCO being a community organization. It is not clear to us that Trillium can now reasonably be considered a community organization. It would help if it followed open meeting laws, reported its finances in a transparent way, and had a governing board that we knew had less than 25% of its members with a financial stake in the CCO, as HB 2122 will require (and should require before OHA renews its contract). At this point, we are prevented from making an appropriate judgement because of the lack of transparency.

Second, there appears to have been far too much excess profit taking that occurred because of the sale. We won't go into all of detail that has been reported in newspapers, but enough to explain our concerns. Information comes from a number of articles and editorials published in the Register Guard, and referenced below.

Rough calculations suggest that a 10% annual return on the original 1996 investment would have yielded $11 million. No one would have been upset with investors getting that sort of generous return, and perhaps even twice that. But it appears that the overall profit taking was more than ten times that amount. If all the investors got was twice a 10% annual return, Trillium would have had over $100 million more to spend on patient health care, or perhaps even on the social determinants of health. Imagine the benefit to Lane County if it had $100 million extra to spend on housing?

If the CCO were a community organization, following open meeting laws, with a board that had no more than 25% of its members with a financial stake, we don't think such a diversion of funds to individuals would have been allowed. If the CCO were a non-profit, such a thing would not have occurred. The reforms in HB 2122 are important.

Some suggest that as long as a CCO is meeting its metrics and contractual obligations, why should we care? The problem is that the metrics and contractual obligations are too coarse. Without financial transparency and accountability, it is too easy for a complex organization to skim a bit here and there to amass a substantial profit. Some of the articles in the Register Guard suggest that providers were very unhappy with reimbursements from Trillium, but of course Medicaid payments are already very low compared to private insurance. A CCO reimbursing a bit lower does not necessarily raise sufficient red flags when there is not appropriate transparency and accountability.

Register Guard articles and editorials regarding Trillium, Agate Resources, Centene

http://projects.registerguard.com/rg/news/local/34498985-75/agate-resources-insiders-made-34-million-on-last-years-sale-of-centene.html.csp
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Thanks for seriously considering our comments.