Trillium
Community Health Plan

UO Riverfront Research Park
1800 Millrace Drive
Eugene, Oregon 97403

Date: February 27, 2017

To: Chair Greenlick
House Committee on Health Care

From: Debi Farr, Manager, Government Relations
Trillium Community Health Plan

Re: Written Testimony, House Bill 2122

Chair Greenlick and members of the Committee:

On behalf of Trillium Community Health Plan, we appreciate the opportunity to provide comment on **House Bill 2122**, which modifies some of the requirements for Oregon's Medicaid Coordinated Care Organizations (CCOs). Trillium Community Health Plan is dedicated to the vision of CCOs as a system of care tailored to meet the needs of their local communities, and we are committed to the continuing growth and evolution of the CCO model. Trillium is proud of the work that we do on behalf of our community to improve the lives of the Oregon Health Plan members we have served for over 20 years. Our work involves many ongoing efforts, some of these include:

- ✓ A strong and unique public/private partnership with Lane County;
- ✓ Integration of behavioral health services;
- ✓ A broad and community-focused governance structure;
- ✓ An emphasis on cultural diversity as well as both rural and urban healthcare needs reflecting the communities we serve;
- ✓ Extensive investment in primary health infrastructure, health care transformation and prevention services; and
- ✓ Partnership in planning and executing an updated Community Health Improvement Plan that prioritizes the needs of our community, including social determinants of health.

Our comments on **HB 2122** are provided in the context of what we have achieved together as a state over the last five years. We support of the Oregon Health Policy Board's (OHPB's) process and its recommendations for the future of coordinated care in Oregon.

Governance and Transparency

The core philosophy of Trillium Community Health Plan aligns with the goals of the coordinated care model. We believe that quality healthcare is best delivered locally, and we have developed a governance structure that is responsive to those requirements. The Trillium Board is made up of local stakeholders and members of the provider community, including representatives from our Community Advisory Council (CAC) and our unique Rural Advisory Council (RAC). Trillium established two advisory councils to reflect the particular geography of our service area – both the Eugene/Springfield metro area and a large rural swath that extends from the Cascades to the coast. More than half the members of each advisory council are consumer or the parent/grandparent/guardian of consumer members. Meetings of each are scheduled monthly. All Trillium CAC and RAC meetings are open to the public and the first ten minutes of each meeting is dedicated to public comment. This is a governance structure that ensures community voices are guiding our operations and enabling us to provide accessible, high-quality and culturally sensitive healthcare services to our Oregon Health Plan members.

Trillium believes that reducing Board membership for those at financial risk would be disruptive to the successful CCO governance model established in our community. Trillium Community Health Plan's success is due in large part to its partnership with providers, the accountability for our shared risk and the insights they bring to the Board because they are providing care in the community.

Trillium has followed closely and strongly supports OHPB's governance recommendations for the future of coordinated care in Oregon – recommendations based on extensive OHPB discussion and broad public input. OHPB's recommendation would:

- Maintain the current statutory language around structure of the Board, but require public transparency about who is on the CCO governing board and the CAC.
- Require CCOs hold a single public meeting in collaboration with the CAC, as well as collectively sponsor an annual statewide CAC learning collaborative to share best practices around CCO community collaboration and input.

In addition to our support of OHPB's governance recommendations, we support OHPB's recommendation to strengthen CCO fiscal transparency. Trillium currently complies with the extensive standardized financial reporting required under the National Association of Insurance Commissioners (NAIC), and we support a standardized approach to collecting financial data. Given the importance of local flexibility and creativity in negotiating business arrangements with our providers, we recommend that CCOs work with the Oregon Health Authority (OHA) to design appropriate financial reporting requirements, rather than legislate these requirements in statute, potentially interfering with the beneficial nature of CCOs and our unique, proprietary financial relationships with our provider partners.

HB 2122 would also require CCO reserves to be placed into a Community Escrow Fund, with each CCO applying for the use of these funds. OHPB recommends a different approach to improving CCO fiscal transparency, establishing reasonable reserves and setting expectations for CCO investments into our communities. Trillium would support further work with OHA to establish these expectations, but do not support the **HB 2122** proposal to establish requirements in statutes that diminish local control over these funds and hamper our ability to meet fiduciary responsibilities.

Tax status and quality

When the CCO delivery system model was developed, an explicit decision was made by the legislature to allow a variety of legal structures to emerge, recognizing that existing local health care entities had developed various legal structures unique to their organizations. While a comprehensive national source for tax status of Medicaid managed care entities is not readily available, an examination of Medicaid MCOs was conducted by Milliman in 2016. Of the 191 MCOs included in the analysis, 129 were for profit.[1] It appears from Milliman's analysis that most states do not include specific requirements around tax status for their MCO contractors.

HB 2122 requires that all CCOs be nonprofit organizations, with no further definition of nonprofit. However, current CCO legal structures and tax status are highly complex and variable, and the **HB 2122** proposal to impose a nonprofit legal structure on CCOs does not further the goals of Oregon's CCO model and the "Triple Aim" of better health, better care and lower costs.

Concerns that CCO tax status provides an incentive to reduce services or that it might be correlated with performance are not supported by available Oregon data. For example, the state of Oregon uses a common financial ratio, the Member Services Ratio (MSR)/Medical Loss Ratio (MLR) as a measure of financial performance; it is a measure of the cost of services provided to members as a percentage of CCO total revenue. An MSR/MLR makes explicit the proportion of premium/capitation that is spent on administrative costs and profits, which include executive salaries, marketing and overhead. In 2018, all CCOs will be required to meet an 85% medical loss ratio as outlined in the recent CMS Medicaid managed care rule. Of Oregon's eight for profit CCOs, two are below an 85% MSR; of the eight nonprofit CCOs, one is below an 85% MSR. Trillium's MSR is 92%, up from 78% in 2014[2].

There is little available national data on the performance of for-profit vs. nonprofit Medicaid MCOs in terms of access, quality or cost. An older study[3] from 2001 examined for-profit and nonprofit status of Medicaid plans and did not see clear evidence that there were significant differences in care. It found that that non-profits may have more flexibility to provide quality services, but for-profit plans have more resources available to invest in infrastructure for quality and data management. There is no distinct evidence to

[1] Milliman Research Report, "Medicaid risk based managed care: Analysis of financial results for 2015", May 2016. Downloaded on February 14, 2017 from http://us.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf. The Milliman analysis is limited to MCO reporting to NAIC.

[2] Oregon Health Authority, 2016 Mid-Year Performance Report, January 2017.

[3] Landon B. and Epstein A. "For-Profit and Not-For-Profit Health Plans Participating in Medicaid" Health Aff May 2001 vol 20 no 3 162-171 available at: http://content.healthaffairs.org/content/20/3/162.full

suggest a reduction in quality. The authors concluded that at that time there is insufficient evidence on "...how for-profit and nonprofit health plans differ in the way they manage utilization and assure quality of care or how they differ in the financial incentives designed to constrain medical services or increase quality of care provided by member physicians."[4]

Further, an examination of performance data among Oregon CCOs shows for-profit legal status does not negatively impact quality outcomes or performance. There is little differentiation between the for-profit and nonprofit CCOs when examining the outcomes for which CCOs are held accountable (10 of those measures are reported in OHA's 2016 Mid-Year Performance Report, January 2017).

Finally, Trillium believes allowing flexibility in the system to empower communities to craft solutions that serve their unique needs is important. The explicit decision to allow CCOs to reflect the variety of legal structures existing within local health care entities has proven successful. Both for-profit and non-profit CCOs are delivering quality, high performance care for Oregon Health Plan members

Value-based payment (VBP)/Alternative Payment Methodologies (APM)

Finally, **HB 2122** requires CCOs to use alternative payment methodologies to distribute at least 80% of the payments the organization makes to providers. Trillium Community Health Plan supports OHPB's VBP recommendations:

- Increasing VBP utilization through OHA's CCO contracts and administrative rules by instituting VBP expectations for subcontractors and providers related to behavioral health and oral health, collaboration with CCOs to expand VBP arrangements with hospitals and specialists, and requiring that a percentage of CCO spending be value based and reported.

Trillium and its affiliated health plans operate Medicaid value-based payment models in over 20 states, with 80% of all members covered by VBP contracts as of 2016. In addition to Trillium's firsthand experience, our affiliation allows us to draw upon a wide network of expertise around a broad spectrum of VBP models. Given investments in VBP models and the resulting infrastructure, this depth of experience in program design and implementation across a range of rural and urban systems, we are well-positioned to work with OHA to meet VBP expectations outlined in **HB 2122** and in the OHPB recommendations.

Conclusion

Trillium is fully committed to the goals and continuing growth of the coordinated care model. We look forward to working with the Committee, OHA and OHPB to ensure that Trillium Community Health Plan reflects the values and needs of our local communities while meeting the goals of better health, better care, decreased health disparities and lower costs.

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[4] Ibid., p163.