Tina Kotek
Speaker of the House

Mitch Greenlick
State Representative

January 16, 2019

Patrick Allen, Director
Oregon Health Authority
500 NE Summer Street
Salem, Oregon

RE: Barriers to Equitable Access to Health Care

Dear Director Allen,

We share the goal of ensuring all Oregonians enrolled in the Oregon Health Plan have equitable access to care. As you prepare for the next five years of contracting with Coordinated Care Organizations (CCOs), we believe there are unresolved issues that hinder the state's ability to achieve this goal. These issues warrant a broader public discussion.

Data and Reporting

Accountability in health care transformation is impossible without good data. The growth in the "unknown" or "unidentified" client population data hinders the state's ability to ensure equitable access to care. One of our first accountability measures as a state was data collection. The legislature codified our intent to serve all populations by passing and implementing REAL+D legislation. In 2015, 20 percent of Oregon's Medicaid population was considered an unidentified race or ethnicity. That proportion is now 40 percent. The "unknown" category exceeds 30, 40, and even 50 percent for many metrics when disaggregated by race and ethnicity. This trend is especially evident for metrics specific to adolescent health.

The state is currently unable to stratify all metrics by race and ethnicity because of incomplete data. Metrics are informed by various data sources, including total population characteristics collected at enrollment, claims data, electronic health records, and surveys. Communities of color are disproportionately affected by chronic diseases such as hypertension and diabetes. The state has incentive metrics for these conditions, but is unable to stratify them by race and ethnicity because the state has not established a path to receive individualized data. While we wish this were already in place, we understand that your agency is making progress toward receiving individual-level data for these metrics. We want to emphasize the importance of adhering to your 2020 target for this functionality.

The larger data issues affecting the Medicaid program were raised in early 2017 at the Oregon Health Policy Board, when the Health Plan Quality and Metrics (HPQM) Committee reported back to the Board about measure adoption for the 2018 benefit year. It was also raised in subsequent Board meetings when metrics were discussed. In the nearly two years since then, what has the agency learned about the effect of enrollment and renewals on the growth in the "unknown" population and what will be done to correct this issue?

The legislature must be apprised of this work. We respectfully request that your agency work with the Department of Human Services to provide an update specific to the growth of the "unknown" category to the House Committee on Health Care as soon as possible. This presentation should clearly explain what strategies are being employed to correct this issue. Please also provide an overview of the recently released REAL+D implementation report (2019). We look forward to learning about your findings.

Incentive Metrics

It is currently possible for CCOs to earn 100 percent of their incentive payments – even challenge pool dollars – by wholly ignoring or regressing on outcomes for one or more diverse communities. This problem impairs our ability to achieve our shared goal of ensuring equitable access to care. Metrics must move us toward more representative outcomes and should be used to target and support those who are falling behind. While some on the Oregon Health Policy Board have vehemently advocated for progress on this issue, the discussion has taken concerning detours. It is not acceptable to ask communities to wait, or to rely solely on the goodwill of CCOs to improve outcomes, or to point to the absence of a single national standard, or to continue to allow data deficits to debilitate progress.

Strategies to reduce disparities in all forms should be relentlessly pursued. Accountability for this work must be explicitly included in metrics. If a CCO is awarded an incentive payment for meeting an improvement target, it should be because the health of <u>all</u> communities improved. If a CCO is awarded an incentive payment for meeting a benchmark, it should be because <u>all</u> communities met the benchmark. We respectfully request that you provide an update on measure development to the House Committee on Health Care as soon as possible.

It is exciting to see the prioritization of internal health equity plans in the CCO 2.0 RFA, as recommended by the 2017 Transformation Center Report *Opportunities for Oregon's Coordinated Care Organizations to Advance Health Equity*. This is a good step forward.

Metrics Committees

We want to acknowledge that members of the Health Plan Quality and Metrics Committee and the Metrics and Scoring Committee have put in months of their personal time toward tackling this issue. They have lent their vast expertise to create many successful measures that have driven innovation, investments, and delivered outcomes for many Oregonians. We wonder if they are disadvantaged by a system that could better support their work. In October 2018, the Health Equity Measurement Workgroup met for the first time. We are pleased to see the Office of Equity and Inclusion steering this table and acknowledge the agency's leadership in committing staff time to this workgroup. However, we question whether the many subcommittees and workgroups committed to equity highlight a larger issue: representatives for whom these measures will be created are not represented in the main processes and systems that govern this work.

Compliance and Enforcement

We have grown increasingly concerned that the agency has not articulated how it intends to enforce the expanded requirements of CCO 2.0. The agency has recognized the need to bolster enforcement of current CCO contracts. We know you are personally committed to expanding its operations and

compliance functions. The agency has made some progress, including an overhaul of Delivery Service Network reports, that will require CCOs to analyze utilization data to demonstrate, rather than simply attest to, network adequacy. The agency is building upon federal regulations by considering time and distance standards specific to episodes of care, not just provider location. We urge the development and adoption of these standards. The agency also completed the state's first mental health parity review analysis in compliance with federal law. We look forward to learning how the agency intends to continue monitoring mental health parity throughout the CCO 2.0 contract period.

We stand ready to advocate for an agency proposal that would bolster oversite of the state's multi-billion-dollar Medicaid program. It is imperative that the agency have a plan in place prior to the implementation of CCO 2.0. For this reason, an analysis of needs must be completed immediately to identify whether position or statutory authority is necessary. Agency needs, if any, should be presented for deliberation as soon as possible.

We appreciate your time and attention to these matters. The agency must strike a balance between partnering with CCOs and holding them accountable. We trust we can get there.

Sincerely,

Representative Tina Kotek
Speaker of the House

Representative Mitch Greenlick
Chair, House Committee on Health Care

cc Tina Edlund, Senior Health Policy Advisor, Governor Kate Brown
Carla McKelvey, Chair, Oregon Health Policy Board
Representative Rob Nosse
Senator Laurie Monnes Anderson