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# Testimony Before House Committee on Health Care

Representative Mitch Greenlink,  
Chair



Tayo Akins, President & CEO, Cascade Health Alliance, LLC

Good afternoon Chairman Mitch Greenlick and the distinguish members of the Health Care Committee. My name is Tayo Akins, and I am the president and chief executive officer of Cascade Health Alliance, commonly referred to as CHA. With me today is Maggie Polson, our chief operations officer.

Thank you for the invitation to appear before you today as you examine the progress of Coordinated Care Organization (CCO) implementation and its impacts. I want to start by addressing four topics posed to us via a letter from Chairman Greenlick dated May 15, 2015.

The four topics are:

1. Our CCO governance structure and the role of our community advisory council;
2. Fundamental health care changes
3. Integration of physical and behavioral health; and
4. Quality measures

I would like to address these four topics before I take any questions.

First, CHA is a for-profit mission-driven organization that was the last CCO to be certified by the State and we became operational on September 1, 2013. However, we have over 20 years of experience in serving the low income and the underserved population in Klamath County. In 1994, we began serving Medicaid pediatric members with the sole purpose of creating access and delivering high quality care in a low cost setting, and by 1996 we were serving both pediatric and adult members. As a CCO, our goal is to integrate our physical, behavioral, dental and pharmacy services for our Medicaid members in a holistic way by knowing our members, caring for our members and advocating for our members. As part of this transformation, we are exploring enhanced innovative payment structures that align all stakeholders around the triple aim and more.

Before I describe the composition of CHA's Board of Directors, I would like to describe Klamath County so that you have a better perspective of our community and some of the potential barriers that we face in delivering health care and transforming it to have better quality outcomes, lower cost for our customer, Oregon Health Authority, and drive the triple aim goals. We view the Oregon Health Authority as our state customer in a public-private partnership to serve our low income and vulnerable population in Klamath County. Klamath County has a total population of approximately 66,000 people with a land area of approximately 6,000 square miles compared to Portland metro area that has a population of approximately 1.7 million people with a land area of approximately 3,000 square miles. Hence, we are a rural county because we have more land than people relative to an urban area like Portland Metro that has more people than land. As of the end of 2014, we have an unemployment rate of approximately 9.7% in Klamath County compared to Oregon state unemployment rate of 6.9%,

and the national unemployment rate of 6.2%. It is very easy to look at health care delivery from the urban prism, but the plight of the rural health care social challenges are real and more severe – lack of access of adequate providers, qualified talented staff, poverty, transportation, education, homelessness , unemployment, food access and personal safety are much more extreme than the urban area.

CHA is composed of a thirteen member Board of Directors. We have representation from primary care physicians, specialists, hospital executives, dental, behavioral health and substance use disorder, a community member, and the chair of the Community Advisory Council. CHA is owned equally by the primary care physicians, the specialists, and our local hospital. The risk is spread equally amongst the three owners.

Our Community Advisory Council (CAC) is a very active part of our company. Though we were not yet a CCO, CHA was a sponsor of the community health assessment in 2012-13 to ensure our community would know the status of our health and more importantly, what areas needed improvement. Having participated in the community health assessment, which focused on our Medicaid population, facilitated our CAC's writing of the community health improvement plan. As mentioned before, we were the last CCO to come on board, however, through our CAC's efforts, we have aligned our community health improvement plan deadlines with the rest of the CCOs. Our first CAC event was the 2013 CCO Summit held in December in Portland; the CAC had not had their first official meeting, however, the members were excited to learn from and begin building relationships with other CAC members invited to the Summit. Oregon Health Authority requires the CAC to meet at least quarterly, however, our CAC is so excited to catch up to the other CCOs and begin implementing the community health improvement plan that we meet on a monthly basis. We have grown from a membership of seven to currently having thirteen members. Our CAC is open to the public.

The three areas the CAC has determined CHA should focus their efforts on are: Healthy Eating and Active Living; Social and Mental Well-being; and Transportation. As a county, Klamath ranked 33 out of 33 counties which participated in the annual statewide survey as it relates to health outcomes. Additionally, only one in four of our members have reliable transportation, therefore, transportation needed to be a priority. The CAC is using flexible funds to enhance our members' need to begin exercising and living a more active lifestyle with the goal of promoting a healthy community. Also, we have partnered with our YMCA so that our members can attend the gym for 20 visits, at which time their progress is evaluated and it is determined if they need additional visits. Within the Social and Mental Well-being initiative, we are encouraging pregnant members to participate in smoking cessation programs, whether through our own in-house program or those provided by Public Health and our local Federally Qualified Health Clinic (FQHC).

In 2014, the company paid over half a million dollars in local, state and federal taxes. CHA is a local reliable community partner that has sponsored events like Relay for Life, Boy Scouts of America, high school sports programs, and various health fairs.

As a CCO, CHA is obligated by its OHA contract to deliver services on a per-member-per-month basis set by Oregon Health Plan. CHA's goal is to deliver services within the framework of its contract with the state. If executed successfully, we will make a profit; otherwise, we will incur a loss for which our shareholders will be financially liable. To date, retained earnings have been used for future reserves, distributed among risk-bearing providers and invested in infrastructure to support our continued growth.

In the 21 months we have been a CCO, we have increased capacity for our members to be seen by a Primary Care Physician from 10,600 members to over 17,500 members. This 65% increase in membership has created infrastructure challenges. Due to these challenges, we are increasing the cost of staff, technology and processes that increase our value for our members and allows us to deliver more effectively and efficiently on our contract with the Oregon Health Authority. We are in the process of increasing staff to meet the demands of the higher membership. With increased staff, we are in need of additional technology infrastructure. Our current care management system is no longer adequate to meet the complex needs of integrating care and transforming the delivery of care using an innovative model of care that is measurable, impactful and accountable. Health care has been used as a tool to care for the sick, but we have to focus on keeping our members healthy and creating a healthy environment while providing quality services. Through the Transformation Funds we have purchased a new system that is specifically designed for care management and is being customized for our CCO. This new system should be operational by the end of 2015 and should have results data by second quarter 2016.

Second, there are three other Transformation Funds projects we would like to highlight to give you an indication of how a little seed money has gone a long ways in our rural community:

Non-Emergent Medical Transport/Community Healthcare Workers- we partnered with our local hospital to not only transport our "chronic users" to their appointments, but also accompany them to their medical appointments to become familiar with their needs. If necessary, the Community Healthcare Worker will take the members grocery shopping for appropriate food for their diabetes, high blood pressure etc., and take them to their pharmacy to fill their prescription(s). The program has been so successful that the hospital has taken it on as a self-sustaining project once the Transformation Funds run out.

Mobile Crisis Team (MCT) – provides behavioral health intervention when members are "acting out" in Providers' offices or out in the community. The 911 operators dispatch police so

they can assess that the situation is safe for the BH workers to triage the member. Most of the members for whom the call is initiated, are in need of behavioral health intervention and not a jail cell. One of the first calls was to Wal-Mart for a member who was off his medication and was talking to himself and had started to undress. Before the inception of the MCT, this member would have been taken to jail and charged with indecent exposure, loitering, trespassing etc. This member instead received a mental health evaluation and appropriate services were put in place. Due to the seed money provided, the institution running the MCT qualified for matching grants which reduced the cost of the program, and received two used vehicles from the local police department to use in transporting our members. Both of these cost savings allowed us to spread the Transformation Funds to other projects.

Pine View – Adolescent (12-16 year old) respite home – One of only a handful of children's homes in Oregon. We saw the need to keep the children locally in Klamath Falls, rather than shipping them out to other communities. Many of these children are removed from their homes, through no fault of their own, and they are further traumatized by being removed from their communities. Now the children can stay in the community, go to their same school, and have local peer support. In the past, we have had up to 20 children in out of area homes, currently there are no Klamath Falls children placed in out of area homes. Pine View is such a success that there are other CCOs lining up to have their children be admitted to this program. Again, due to matching grants, this project did not use up all its allocated monies.

Third, we are integrating physical, mental and behavioral health through the effective use of Patient Centered Primary Care Homes (PCPCH). Over 67% of our members are assigned to Tier 3 PCPCHs. We have had behavioral health care providers embedded in three of the four PCPCHs and are working on the logistics of having the fourth PCPCH on board in the next quarter. Our Family Medicine Residency Program (an OHSU Residency Program), has two behavioral health (BH) providers, one a masters level provider and one a PhD level provider. Our local FQHC has a master's level behavioral health provider on premises and members needing BH services are immediately referred to him. One of our pediatric clinics had a pediatric psychiatrist in house one day per week which fulfilled the BH needs of that clinic. Our other pediatric clinic is hiring a BH provider to be embedded in their clinic by third quarter of this year.

Our effort to integrate physical health and behavioral health is crucial for our success as a CCO. When we do our stratification, we know, we can make a tremendous difference with members with high physical health needs and high behavioral health needs. Our current laws regarding exchanging behavioral health medical records with physical health providers creates a barrier for shared information and collaboration of care that drives up cost of health care. We are

actively working with our Jefferson Health Information Exchange (JHIE) partner to find a creative solution to these barriers.

Fourth, regarding the quality measures, in 2013 our CCO met 12.6 of the 17 metrics and were able to receive 100% of the withhold in the quality pool. After the funds were disbursed, the State determined that we had also met one other metric, the Early Elective Delivery metric. The three metrics that were not met were: Screening, Brief Intervention and Referral to Treatment (SBIRT); Colorectal Cancer Screening (per 1,000 member months); and one of the two surveys conducted by the State, the Consumer Assessment of Healthcare Providers and Systems (CAHPS): Access to Care.

Screening, Brief Intervention and Referral to Treatment (SBIRT) – in order to improve our score for 2014, we began by educating the family medicine residents at our local OHSU Family Residency Program's clinic, Cascades East Family Practice. Additionally, we have met with our behavioral health providers to educate them on the process and how to deal with our members once they are referred for services to any of the behavioral health clinics for treatment. And finally, thinking outside the box, we have partnered with one of our DCOs to ensure our dental care providers are also trained on SBIRT. Though all of this training has taken place and SBIRT screenings are being done, we do not receive credit from the State for all the screenings since there have been glitches in documentation and coding by providers. We do not believe we will meet this metric for 2014. Our emphasis for 2015 has been to visit with all provider offices and/or their billing services to ensure proper and adequate documentation and coding is taking place so that we can receive credit for the work that is being done by our providers.

Colorectal Cancer Screening (per 1,000 members months) – we have made great strides in 2014 to meet this metric and believe we will meet it for 2014. We conducted a targeted mailing to members who are at least 50 years old, have not had a colonoscopy in the last ten years, and who have not had a fecal occult blood screening in the last year. We mailed out over 1,000 letters encouraging our members to pick up a screening kit and return it to us or to the lab. When the kit was returned, the members were rewarded with a nominal gift card. While the response rate of 10% seems like a small response rate, we were successful with over 10% of our targeted population. We believe we will meet this metric for 2014.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – we have improved access to providers by opening a new clinic and providing monetary incentives to providers to move to the Klamath Falls area to practice family medicine. We believe we will meet this metric for 2014.

Figure 1:

<b>CCO</b>	<b>Total Complaints/Grievances Received</b>	<b>Enrollment as of 12/31/2014</b>	<b>Per 1000 Members</b>
AllCare Health Plan, Inc.	54	48,568	1.11
Cascade Health Alliance	41	17,002	2.41
Columbia Pacific CCO, LLC	81	28,068	2.89
Eastern Oregon CCO, LLC	51	44,801	1.14
FamilyCare CCO	94	114,893	0.82
Health Share of Oregon	641	233,802	2.74
Intercommunity Health Network	27	55,498	0.49
Jackson Care Connect	58	30,022	1.93
PacificSource Community Solutions	66	50,876	1.3
PacificSource Community Solutions - Gorge	2	12,244	0.16
PrimaryHealth of Josephine County CCO	4	11,054	0.36
Trillium Community Health Plan	240	89,237	2.69
Umpqua Health Alliance, DCIPA	19	25,195	0.75
Western Oregon Advanced Health	98	20,606	4.76
Willamette Valley Community Health	17	101,726	0.17
Yamhill County Care Organization	31	23,950	1.29

*Source: 2014 Q4 Oregon Health Plan Quarterly Report*

While looking at Figure 1 chart above, it may indicate that we have a high appeals rate, the absolute amount is very small compared to the size of the population we serve. However, since we have had a dramatic increase in membership last year, we expect our members to continue to appeal as they transition from open card or fee for service into a CCO model and get better informed and experienced regarding the CCO model. We have an excellent appeals & grievance process, and last year, Acumentra, Oregon Health Plan's external quality review partner, gave us a rating of 3.9 out of 4. I would also like to point out that since the inception of our CCO, we have only had one instance where a hearing overturned the decision of our medical director and staff.

Finally, we should be a source of hope to the low income and the vulnerable, the sick and the disabled, the marginalized victims of health care – not out of charity, but because transformation in our time requires the constant advance of those principles that our common creed describes: tolerance and opportunity, human dignity and justice. Our goal is to

cannibalize our CCO business by engaging our community and working with our community partners to provide better opportunities for our members like the Klamath Works initiatives. As one of our Board members stated, “we are not providing our members a hand-out for work, but a hand-up during their unemployment or under-insured period of their life while they are on Medicaid.” During this transition period for our members, we aim to be their best health care solution partner in conjunction with the Oregon Health Authority. If we are successful, we will have less members on our plan, but we will be remembered by our members that we delivered transformational care during the transitional phase of their lives. At the end of the day, we want to be known as a great health care solution provider for the state and a great partner with the Oregon Health Authority. In doing so, everything must be done to ensure we have adequate rates to adequately serve our members.

I want to thank the members of this Committee for your effort and support in the last few months, and those who have taken the difficult vote that puts us on a path to passing SB 833. As noted earlier in my speech, we view the Oregon Health Plan as our customer working in a public-private partnership to serve our members. As such, everything we advocate for is for our members that we all have the honor of serving.

Mr. Chairman, thank you for the opportunity to address these issues. I look forward to your questions.