Testimony in Support of House Bill 2122A -15
House Committee on Health Care
Speaker of the House Tina Kotek
May 4, 2017

When we started transformation of the Oregon Health Plan back in 2011, our goals were to get better value for the money we invested in care, move away from a fee-for-service model toward value-based payments, provide the flexibility to innovate and address community needs, and do all of this while keeping below a cost curve of 3.4 percent.

Coordinated care organizations (CCOs) have been able to serve Oregon's Medicaid expansion population successfully. Since 2013, approximately 400,000 new people have enrolled. We have also seen initial success through creative investments in the community, a 60 percent increase in patient-centered primary care home enrollment since 2011, and a corresponding decrease in hospital admissions for chronic diseases by 60 percent. This shows good progress.

Still, we have more work to do. When we began this journey we knew we would need to keep innovating and moving forward. House Bill 2122A with the -15 keeps challenging us and moves us in the right direction by formalizing some of the lessons we have learned over the past five years. I support this bill and the effort to make sure that the legislature takes action to ensure that CCOs meet our vision of success 5, 10, and 15 years from now.

I want to specifically call out a few areas that the -15 addresses:

Reserves: CCOs are made possible by Oregonians' tax dollars. They deliver taxpayer-funded care to approximately 25 percent of Oregonians, and it is our responsibility to protect those funds and the people they serve. As it stands, taxpayer money intended to pay for health care for Oregonians has and could end up enriching executives and shareholders. We must address the issue of whether and how CCOs manage their reserves to protect the public's investment. The -15 addresses this by requiring CCOs to invest a portion of annual net income into the community. The portion does not come out of **required reserves, administrative dollars, or money set aside for direct medical care,** we are requiring a portion of excess dollars be invested directly into the community. The -15 accomplishes this through rule, where stakeholders – and it is our expectation that stakeholders include Medicaid beneficiaries, community-based organizations, among others, contribute to the design of this investment.

Furthermore, beginning in 2019, we will require all **new** stewards of the state health plan be a community-based nonprofit or a public benefit corporation. We added B corps as they "are restricted so that on dissolution, the corporation must distribute the corporation's assets to an organization organized for a public or charitable purpose, a state or a person that is recognized as exempt under section 501(c)(3)". We believe this further contains the risk that state dollars, intended for the delivery of health care to Oregonians, could be funneled out of state through sale or merger. It also holds CCOs accountable to their communities.

Transparency: As mentioned, CCOs should be held accountable to the state and the members they serve. I support CCO transparency measures because an enrollee should know what and how decisions are being made about their care. Providers should also have access to this process. This bill institutionalizes basic tenets of CCO operations, and I believe we should build off these basic principles as we move further into the future of health care transformation. The -15 accomplishes this by requiring all governing board meetings be subject to public meeting laws. It is our expectation that, in the case of a CCO that has a contractual relationship with an external governing body, the requirement for adhering to public meeting law is applicable to the external governing body and not to the entity that holds the CCO contract if they differ. There are 14 exemptions afforded to CCOs through current statute, exemptions that allow for executive session when sensitive material is being discussed. We've posted this on OLIS for your reference.

Innovation: When we began this transformation process, the implementing legislation encouraged alternative payment methodologies, under a global budget, to drive cost savings and quality by changing why and how we pay for care. The -15 requires OHA to support CCOs in further institutionalizing alternative payment methodologies (APM) by setting a benchmark, collaboratively, and setting a plan for each CCO to reach said benchmark. We do not prescribe a set percentage in statute nor do we prescribe what or how APMs should look. This is a change from earlier amendments as requested by CCOs.

We have listened and we have amended.

We believe this bill, with the -15, aligns with the Medicaid waiver and is a necessary step to to sustain transformation. More so, it aligns with the basic principles of the Health Policy Board Recommendations.

Thank you for your attention today, and thank you for working hard to continue health care transformation in Oregon.