OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

Date: September 16, 2019

TO: Chair Salinas, Vice-Chair Nosse, Vice-Chair Hayden and Members of the House Health Care Committee

FROM: Patrick M. Allen, Director, Oregon Health Authority

SUBJECT: Response to CCO 2.0 questions in August 23, 2019 letter

---

Dear Chair Salinas and Members of the Committee,

Thank you for the opportunity to address the House Health Care committee about the CCO 2.0 procurement and evaluation process and our work to ensure Oregon's coordinated care organizations (CCOs) meet Governor Brown and the Oregon Health Policy Board's (OHPB) priorities for CCO 2.0.

OHA remains committed to the original principles that made Oregon's health care reforms a national model. Oregon's community-centered CCOs are the cornerstone of our state's health system transformation. This remains unchanged. Under CCO 2.0, CCOs will continue to collaborate with local partners and respond to local needs and invest in non-medical, health-related services to address social determinants of health and equity.

Oregon leaders created the original CCOs to change health care by transforming the way it is delivered. But CCO 1.0 was also born out of pragmatic flexibility. State leaders needed CCOs to be successful and cover every part of the state. No single CCO structural model was prescribed. CCOs could be non-profits or for-profits. Some CCOs were descendants of former MCOs. Some CCOs were wholly-owned by local providers, while others were arms of insurance companies. This flexibility in CCO 1.0 allowed the new system to take hold. And for the most part, it has worked: Unnecessary emergency department use dropped by 50 percent – just one of many measures where CCOs produced positive gains. We've held state costs under our Medicaid waiver to a 3.4 percent growth rate. Today, more OHP members say they are healthier.

But there is more work to do. Too many communities suffer unacceptable health disparities. Oregonians need better behavioral health treatment. We can do more to hold costs to a sustainable growth rate. Governor Brown has established four improvement priorities for CCO 2.0: 1) Improve behavioral health; 2) Address social determinants of health and health equity; 3) Increase value and pay for performance; and 4) Maintain sustainable cost growth. Thousands of Oregonians affirmed these priorities in public meetings, online surveys and a 10-city listening tour. OHPB directed OHA to pursue these goals in the CCO 2.0 contracts that take effect on January 1, 2020.

CCO 2.0 has been designed to meet these goals while staying true to the hallmarks of the original CCO vision. And we have done this work through a transparent and responsive process, providing opportunities for feedback, questions, and the opportunity to review CCO 2.0 documentation along the way.

I want to address some of the concerns I've heard voiced about CCO 2.0:

- **CCO structure**: No, we are not shrinking the field in favor of fewer, larger organizations. It turns out when we announced our intent to award new CCO 2.0 contracts, a total of 15 applicants qualified – the same number of CCOs we have today. We continue to have a mix of for-profit and non-profit entities, with a wide variety of organizational structures.
- **Local partnerships**: Yes, CCOs must continue to have deep roots in their communities. While local leaders may prefer one applicant over another, any applicant that meets OHA's higher bar for CCO 2.0 will get a contract. Applicants must show they have a network of providers who can serve OHP members and strong local partnerships with counties, housing agencies, schools, human service providers.
- **Financial accountability**: Yes, OHA is borrowing the same tools state insurance regulators use in the commercial market, but we are not turning CCOs into insurance companies. We do not want to limit CCO ingenuity, just safeguard their financial stability.

While the players evolve and the maps shift, the core philosophy of the coordinated care system remains unchanged. I look forward to working with stakeholders across the state to achieve the goals of CCO 2.0.

In response to the questions outlined in your August 23rd letter, please see my answers below.

In reading the evaluation criteria, it appears the evaluations were done solely based on whether the respondents' answers were complete, responsive and detailed. Was there any other evaluation of submissions concerning whether the information provided was relevant, effective, proven or achievable?

General Evaluation Criteria and Scale
This is incorrect. Submissions were initially evaluated to assess whether responses were: complete, addressing every component of the question; responsive, on topic, avoiding unrelated subjects, answering the question that was asked in a manner that was reasonable and feasible; and detailed, with specificity and providing a description of the process, strategy or program in question. Each CCO received a deficiency analysis for each of the evaluation categories that showed where the evaluators found concerns. The confusion may be that if a submission was incomplete, nonresponsive, or lacked detail, there was not more to evaluate. There were examples such as with one applicant where we asked for details on how their Preferred Drug List program aligns with OHA's fee-for-service Preferred Drug List. The answer provided gave no detail how it was aligned or provided the criteria for when it is not aligned. The answer was not detailed, not complete and not responsive and, accordingly, received a poor score.

Where applicable, submissions were also evaluated to assess whether responses were effective, proven or achievable. This was done by providing each review team evaluative criteria for each question. The teams focused their evaluations on the answers furnished in

response to each of the questions, and the evaluative criteria asked if the answers provided enough detail to substantiate the answer given. In most cases, the questions that were asked were looking for prospective plans, so, again, the evaluative categories focused on whether the answers were complete, responsive and detailed. Many of the new policies in CCO 2 are prospective, making it difficult to judge responses from a historical perspective. But for related questions, the evaluation sought responses describing how an applicant planned to achieve the new policy objectives. Reviewers applied the 'complete, responsive, detailed' framework outlined above to judge the achievability, feasibility or reasonableness of the proposed plan.

We are concerned that, with the evaluation scale OHA utilized, a respondent could have provided a response that was complete, responsive and detailed but may not necessarily meet the desired outcome of CCO 2.0. How did you determine if an applicant could implement what they included in their response? Did you analyze their experience in meeting the requirements of the CCO 2.0 contract and if so, what experience was evaluated? Was the carrier's ability to work with community members to expand seamless access considered in the evaluation of the applications? Were the applicants' delivery system networks considered?

How did you determine if an applicant could implement what they included in their response?

Readiness Reviews
As required by federal regulations, OHA is conducting readiness review prior to the start of the contract period to establish whether a successful applicant has the capability to begin serving members, which, from a practical standpoint means whether they can implement what was included in an applicant's Request for Application (RFA) response. This process take place from July through November and is broken into two sections. The first phase focuses on the most critical functions included within the RFA response. Critical functions are any function that directly impacts a member's ability to access services including underlying systems, coordination of care, and coverage and authorization of services. This phase will be completed by the end of September. The second phase will look at portions of the RFA response that would not as likely impact member access and could be addressed more easily over time including CCO governance policies, administrative staffing, and some policy protocols. The phase will be completed by the end of November. OHA is currently working with its vendor to determine whether all successful applicants' responses establish they have systems, processes, and infrastructure in place to provide services to Oregon Health Plan (OHP) members. If an applicant fails readiness review, then OHA has the options to not award a final contract, make adjustments to enrollment, reduce the number of contract years awarded, reduce service area, or delay the start date for that CCO.

Did you analyze their experience in meeting the requirements of the CCO 2.0 contract and if so, what experience was evaluated?

Request for Application Process and Prior CCO Experience
No, we did not evaluate applicants based on whether they had current experience as a CCO. The CCO 2.0 procurement process was intentionally designed to be prospective in order to be open to all applicants who met the stated minimum criteria. The minimum criteria required an applicant to have experience as a health care risk-assuming entity in Oregon. However, while several of the RFA questions were prospectively written, most applicants referenced their

current practices when asked to describe how they would achieve CCO 2.0 policy objectives. That experience was analyzed as part of the overall response.

Was the carrier's ability to work with community members to expand seamless access considered in the evaluation of the applications?

Yes, applicants' ability to work with community members to expand seamless access was considered. Applicants were asked to describe their demonstrated experience and capacity for engaging community members and health care providers in addressing regional health disparities, for providing culturally relevant care coordination services for the American Indian/Alaska Native population, for administering prescription drug benefits, and for managing financial risk. Responses to each of these questions were evaluated. More broadly, community engagement was specifically evaluated and scored for each applicant by analyzing the proposed community engagement plan and an applicant's level of community engagement during the development of the Application.

Were the applicants' delivery system networks considered?

Delivery System Network Evaluation

Yes, applicants' delivery system networks were considered. All applicants provided a preliminary delivery system network (DSN) report, indicating which providers were currently under contract with the applicant, as well as those providers who were not under contract but where the applicant could provide written documentation of the provider's willingness to enter into contract negotiations if an award was made. OHA sampled these submissions to ensure validity. An assessment of each successful applicant's DSN is being conducted during readiness review.

OHA did not receive any applications from any organization without an existing provider network. OHA was aware that new entrants or applicants expanding their current service area would likely need additional time to finalize contracts with providers. Applicants must build a provider network adequate to meet the needs of the members in that CCOs service area as a condition to any contract award. OHA expects that any organization that received a notice of intent to award is working to establish provider contracts now.

Oregon's vision for a coordinated care delivery model has always been predicated on a community-based model where the community drives decisions for the organizations. That's why there were so many different CCOs when they were established. Oregon was deliberate in trying to prohibit out of state, out-of-touch managed care organizations from obstructing the community-based model, to one of reducing cost by limiting benefits and treatments with the sole purpose of siphoning profits back to its home state.

Oregon designed community-based organizations that placed the ownership (and risk)—literally and figuratively—in the hands of providers in the delivery system who could identify innovative solutions to change the way health care is being delivered. We did so because we knew the status quo managed care system was simply unsustainable.

Given that three of the four applications denied included support and even financial participation of a major portion of the delivery system providers in those communities,

it raises questions about the process. Several newly awarded contracts seem to favor large, insurance-carrier based models over locally controlled approaches.

- ***Isn't this a departure from the original intent of CCOs and how do you reconcile the original vision and intent of CCOs with the contract awards?***
- ***How was support from the existing system providers considered when reaching a denial determination?***

Original vision and intent of CCO 2.0

We are not changing the core of the CCO model. In CCO 2.0, CCOs will stay true to the hallmarks of the original CCO vision: inclusive community governance; effective investments in housing, food security and other social determinants; strong partnerships with counties and nonprofits aimed at improving the health of local communities. The priorities of CCO 2.0—improving behavioral health; addressing social determinants of health and health equity; increasing value and pay for performance; and maintaining sustainable cost growth—are complementary to the hallmarks of the original CCO model.

Provider Engagement in Evaluation Process

OHA did not engage with providers as part of its evaluation process. No assumption was made with respect to the provider network of any applicant, new or established. The decision to award was based on whether the applicant demonstrated the ability to achieve the objectives of CCO 2.0 through their responses to RFA questions including the applicant's representation of its provider network. OHA is currently analyzing adequacy of the provider networks and has asked CCOs to submit their provider contracts and are sampling those submissions to ensure that the networks presented to OHA are fairly portrayed. Adequacy of provider networks is also being analyzed. Providers may choose whether to continue a business relationship with a CCO, or not, for a variety of reasons, OHA evaluated the responses submitted by each applicant based on the RFA criteria.

What was the evaluation process and criteria considered for an organization to be awarded a contract with no existing provider network?

The same evaluation process and criteria were applied to all applicants regardless of the size of existing provider networks. OHA did not receive any applications from any organization without an existing provider network. As described in more detail above, applicants submitted a DSN, which has been validated by OHA. Network adequacy is a condition to any contract award and is being evaluated in Readiness Review and will be evaluated again before contracting.

How do you foresee carriers without existing networks or relationships with providers establishing contracts and how was that specifically considered in the contract awards?

OHA did not receive any applications from any organization without an existing provider network. As described in more detail above, applicants submitted a DSN, which has been validated by OHA. Network adequacy is a condition to any contract award and is being evaluated in readiness review and will be evaluated again before contracting.

Why were CCOs with established networks and proven track records denied contracts while CCOs without any network presence in the community awarded contracts?

OHA did not receive any applications from any organization without an existing provider network. As described in more detail above, applicants submitted a DSN, which has been validated by OHA. Applicants who were not awarded contracts failed all or nearly all the evaluation, or they were deemed too financially unstable to proceed.

Blinded Review Process

Applicants' identities were blinded, allowing reviewers to evaluate their submissions without being able to identify the applicant, focusing solely on the criteria being evaluated and using systematic and the decision to award was based on the same factors.

Financial Solvency Evaluation

Each applicant's financial information and solvency analysis was evaluated in the same manner. Staff from OHA and the Department of Consumer and Business Services (DCBS) reviewed applicants for financial solvency based on their financial pro formas, including assessing the validity of the assumptions made on pro formas. If the applicant's financial pro forma was based on unreasonable assumptions or projections that did not adhere to the requirements outlined in the RFA, an additional analysis was performed using the range of assumptions originally requested. For example, unreasonable assumptions were assumptions that might refer to enrollment trends based on the available membership in the requested service area, cost trend increases that significantly exceed projected rates for that area, or errors in the so-called 'stress test' data provided by the applicant. In all cases, any assumptions made, beyond those made in the original submission, to perform a comparable financial analysis across applicants were clearly noted in the summary.

In some cases, providers who had participated with a CCO decided not to maintain their relationship with that CCO in the bids for CCO 2.0. Did you consider why providers made these choices? In reviewing your evaluations, it appears OHA automatically assumed existing CCOs would continue providing service in their established territory without regard to the decisions' providers had made about continued participation with the CCO. Did OHA check with providers to see if this assumption was correct, or how was this conclusion reached?

Provider Choice Considerations

Because providers may choose to continue a business relationship with a CCO for a variety of reasons, OHA evaluated the responses submitted by each applicant based on the RFA criteria. No assumption was made with respect to the provider network of any applicant, new or established, but rather the decision to award was based on whether the applicant demonstrated the ability to achieve the objectives of CCO 2.0 through its responses to RFA questions including the applicant's representation of its provider network and its network adequacy.

Provider Assumptions

OHA made no assumption with respect to the provider network of any applicant. OHA is currently sampling provider network reports to assure that the networks presented were portrayed correctly.

In some circumstances, the CCOs awarded contracts said they could not serve all of population currently covered by CCOs. If the new CCO is unable to take all of the Medicaid recipients in an area, what happens to those members? Do they move to fee-for-service?

Enrollment Capacity
CCOs were asked to model a range of assumptions, including enrollment capacity, and many did so under the assumption they would not be the only entity awarded. The maximum enrollment capacity is established during the readiness review process when final financial documents are submitted for review. OHA is working with all applicants based on the information provided to date to evaluate the network and make a determination of whether the applicant will be able to take in the projected OHP members in the service area.

If OHA signs a five-year contract with a CCO and the CCO is acquired, purchased or in some way changes ownership, what ability does OHA have to revisit that contracting decision?

Regulation of Mergers and Acquisitions
OHA has new regulatory tools under SB 1041 to allow or not allow such a transaction to proceed. Among the factors OHA will consider in its regulatory review are whether the transaction would be consistent with the CCOs obligations under CCO 2.0 and whether it would have any detrimental impact on OHP members.

Can you provide a detailed description of whether each CCOs financial information and solvency was evaluated in the same manner and if not, specifically how and why each CCO was evaluated differently?

Financial Solvency Evaluation
Each applicant's financial information and solvency analysis was evaluated in the same manner. Staff from OHA and DCBS reviewed applicants for financial solvency based on their financial pro formas, including assessing the validity of the assumptions made on pro formas. If the applicant's financial pro forma was based on unreasonable assumptions or projections that did not adhere to the requirements outlined in the RFA, an additional analysis was performed using the range of assumptions originally requested. As an example, unreasonable assumptions could refer to enrollment trends based on the available membership in the requested service area, cost trend increases that significantly exceed projected rates for that area, or errors in the so-called 'stress test' data provided by the applicant. In all cases, any assumptions made, beyond those made in the original submission, that were necessary to perform a comparable financial analysis across applicants were clearly noted in the summary.

There were three sections that appeared to evaluate CCO financial stability in the evaluations – a letter from DCBS, a letter from ASU and then the overall evaluation of the questions related to finances from your team of evaluators. Did the team of evaluators review the DCBS or ASU responses?

Finance team Evaluation vs. DCBS/Actuarial Services Unit analysis
The labeling of the evaluation could have more clearly explained that the "Finance" section in the evaluation and the reviews by DCBS and OHA's Actuarial Services Unit (ASU) were two

distinct areas of review. The Finance section scored by reviewers was based on responses characterized as financial policy and cost containment. The financial stability/financial pro forma analyses performed by DCBS and ASU were separate examinations and covered the financial pro forma submissions.

The Finance section evaluation scored the narrative RFA responses related to Pharmacy Benefit Manager arrangements, tracking and reporting of social determinants of health and health equity expenditures and outcomes, quality pool funds, Health Related Services investments, managing within the global budget, and sustainable growth. These narrative responses (the Finance section) were evaluated by a team of subject matter experts who focused exclusively on the policy objectives of CCO 2.0 and did not assess the financial stability of the applicant.

In a totally separate exercise, financial stability was reviewed by DCBS and ASU based on the applicant's financial pro formas and included an assessment of the underlying validity of the assumptions made by the applicant when completing the pro forma projections. OHA did not have the same people perform both parts of these evaluations as described above.

How is it possible for an applicant to pass the finance section if DCBS and ASU raised significant concerns about their financial submissions?

These were two separate areas of review, as described above. Applicants could have received a passing recommendation on their responses to Finance section which focus on cost containment and policy questions, while failing the financial stability examination performed by DCBS and/or ASU. The analyses performed by DCBS and ASU were standalone assessments of the financial stability and the underlying assumptions made in the applicant's financial pro formas.

Our understanding of the evaluation criteria you used is that an applicant scored a 4 or 5 that meant they passed because the evaluators determined the applicant's response was, again, "complete, responsive and detailed." How did applicants receive a 4 or 5 and then had the box checked for "Lacks Detail"? How did applicants receive a 4 or 5 when DCBS and ASU stated there was not enough information available to make a determination?

The table included in the final evaluation report comprises multiple questions within a section, with combined deficiency comments from reviewers. Applicants could have scored a 4 or 5 based on the narrative response to some questions in the Finance section and failed to provide sufficient responses on other questions in the same section. Each Finance evaluation reviewer scored all applicants based on the information provided in the narrative response independent from the information needed by DCBS and ASU to perform a financial stability analysis.

Finally, several CCOs are facing a short-term, one-year contract. The award announcement stated, "If a CCO does not receive a contract beyond one year, OHA will work with the local community to cover that service area through another CCO." What will happen if arbitrary decisions force one or all of them to close their doors? What

kind of "work" can we expect OHA to perform with the local community to ensure adequate service?

OHA's decisions whether to extend or terminate the short-term CCO contracts will not be arbitrary. These decisions will be based on the evaluation of the readiness of the CCOs who received one-year contracts to meet the overall goals of CCO 2.0.

One-Year Contract Awardees

OHA announced its intent to award one-year contracts to four applicants. These applicants did not fully demonstrate their ability to sufficiently meet the CCO 2.0 criteria, but denying their applications would have left gaps in CCO coverage. OHA is currently working closely with each of the four CCOs who received one-year contracts to develop remediation plans that will instruct each CCO on what it needs to show to alleviate the documented and major concerns that were identified during the evaluation process.

If the CCOs deficiencies are appropriately mitigated between now and May 2020, OHA intends to award the remaining four years of the contract period. If overriding concerns remain by that time, or the CCO has not taken steps to achieve the milestones in the remediation plan, OHA will work closely and transparently with the local community to determine how best to meet the needs of the OHP members in that community. OHA would then complete a new application process to allow CCOs in other service areas to fill the needs of those members.

Thank you for your time. For more information on the CCO 2.0 evaluation and process and awardees, please visit: https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0-Awardees.aspx.

Thank you.