August 23, 2019

Director Pat Allen
Oregon Health Authority
500 Summer Street, NE
Salem, OR 97301

Dear Director Allen:

Thank you for the work you and your team have provided over the past several years as we have transitioned to you as the new Director of the Oregon Health Authority (OHA) while maintaining Oregon's vision for health care transformation and the triple aim. We recognize that OHA has experienced several challenges as we move toward building on our successes while avoiding future mistakes under the Oregon Health Plan (OHP) and the Coordinated Care Organization (CCO) delivery model.

We have appreciated OHA's transparency with the House Committee on Health Care and expect to see that same level of disclosure as we move into CCO 2.0. With that expectation in mind, we have received several concerns from stakeholders that have raised some questions with regards to the process for selecting CCO carriers, as well as the capacity for access and a seamless transition in every region. We hope you will be able to respond to the following questions and that we can follow-up with a dialogue in the upcoming Health Care Committee informational hearing next month.

As the state moves forward with the next round of CCO contracts, we must build on the successes achieved to date by enhancing the current model to further provide access to eligible members. It makes sense that the contract evaluations included a carrier's ability to expand social determinants of health and health equity, integrate behavioral, physical, and oral health as originally envisioned and that the evaluations ensured all CCOs work with their community partners to address community priorities. In advance of our hearing next month, we would appreciate answers to the following questions to help us and our committee better understand the decision making involved in selecting CCO's. We thought getting these questions to you in advance would give you a chance to answer the questions and clarify the questions with us before legislative days so you are as prepared as possible.

- **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?**

- **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?

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?**

Furthermore, network adequacy, access to providers and enrollment projections are a top concern as we enter this second round of CCO contracts.

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

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

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

- **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?**
- **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?**

- **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?**

Financial viability is also a concern as Oregon experienced issues with a contract breach in the past. It is understandable that you would place a great emphasis on this particular criteria in your decision making process. However, it is unclear how those financial projections were evaluated and how decisions were actually made based on financial information.

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

- **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?**

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

- **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?**

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?**

Thank you in advance for responding to these questions. CCO 2.0 is an extremely important step in continuing this unique Oregon investment in healthcare. We want to ensure that the legislative intent envisioned when CCO's were created advances with CCO 2.0.

Sincerely,

Andrea Salinas
Andrea Salinas
State Representative
Chair, House Committee on Health Care

Rob Nosse
State Representative
Vice-Chair, House Committee on Health Care