April 4, 2017

Senate Committee on Health Care
Senator Laurie Monnes Anderson, Chair

Chair Monnes Anderson, Vice-Chair Kruse, members of the Committee,

Thank you for the opportunity to testify today in strong support of Senate Bill 233, specifically the -2 amendments sponsored by Senator Kruse.

This legislation is about requiring actuarial soundness for each CCO and requiring transparency of the rate-setting process. SB 233 would also require that OHA conform to the legislative intent for global budgets for CCOs in current law. This legislation is critical in helping us understand OHA's rate development process today, and is in line with CMS principles regarding actuarial soundness.

The following comments from CMS on actuarial soundness in their 2016 Medicaid rule encapsulates why we believe the legislation is necessary and in keeping with current standards.

"….capitation rates should be sufficient and appropriate for the anticipated service utilization of the populations and services covered under the contract and provide appropriate compensation to the managed care plans for reasonable non-benefit costs…actuarial rate certification underlying the capitation rates should provide sufficient detail, documentation, and transparency of the rate setting components set forth in this regulation to enable another actuary to assess the reasonableness of the methodology and the assumptions supporting the development of the final capitation rate…" (https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered?TB_iframe=true&width=921.6&height=921.6)

In the amendment to this legislation in Section 2, we are including the CMS definition for actuarial soundness from 42 CFR 438.4 which states, "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract". This will conform the rate development process to the CMS standard and guide OHA's rate development for 2018 and beyond.

As you know, FamilyCare has been requesting the regional base data from OHA to help our independent actuary determine whether our 2017 rates are actuarially sound. FamilyCare believes that our 2017 rates are fundamentally flawed because of policy decisions and clawbacks used to develop these rates. One of these clawbacks is a $34 million arbitrary reduction in our primary care payments from the base data used to develop our 2017 rates. The explanation given to us by OHA was that we pay our primary care providers too much. This violates the global budget provisions in state law and contradicts the state's own research showing that investment in primary care leads to overall savings in the health care system.

Our actuary, Milliman, says that our 2017 rates will result in a loss of approximately $50 million for the company in 2017. As shown in this exhibit, FamilyCare continues to be the lowest paid CCO in the state, with a reduction in our rates of 15.6% since 2014. Conversely, the state's CCOs saw an increase of 4.3% during the same period. Our rates have resulted in a $56 million reduction to our reserves for 2015 and 2016.

Section 3

Transparency in the rate-setting process is crucial, and the provisions in Section 3 of the bill will get us there. Section 3 would require the disclosure of aggregated (or average) base data used to develop rates for all CCOs, but not individual contractual relationships between CCOs and providers. Prior to 2012, this data was made publically available in a comprehensive data book which any managed care organization could use as a comparison tool. This base data is used as a starting point by an actuary in the development of capitation rates for a specific population or category of service.

In contrast to OHA, CMS publically discloses this aggregated base data by individual plan for the Medicare Advantage program. The exhibit on the screen shows the level of data that CMS makes available for each individual plan. The next exhibit shows what OHA makes publically available for OHP. The majority of the information is completely blacked out and useless to any actuary working to validate actuarial soundness.

The bottom line is that prior to 2012, the state reported the Medicaid data it used to develop rates, and now it is not. In the case of Medicare Advantage, the data is online and accessible to any actuary who wants to review it.

Section 4

Section 4 would return the rate development process to the way it was done for 20 years when CCOs had a truly global budget that allowed for flexibility and innovation. This

language would prevent the kind of arbitrary line-by-line adjustments and clawbacks used by OHA that violate the global budget provisions in state law.

Section 4 would also restore the single statewide risk score methodology, the most accurate and rational approach to rate development for the Oregon Health Plan. Up until 2015, this methodology was used reliably by the state for rate-setting, and would allow for modifications to rates based on the demographics of each CCO. OHA's switch to regional rate-setting has led to wide, unexplained discrepancies in rates across the state.

Section 4 would also address uniformity in OHA's reporting of CCO data and timeliness in receiving quality metrics from the state. The very last provision in this section would allow any CCO to appeal their rate determinations with the Department of Consumer and Business Services. No process like this exists today. Had it been in place in 2015 and 2016, FamilyCare would never have needed to file a lawsuit to challenge our rates.

Section 5

The last section of the bill establishes this independent appeal process at DCBS. We believe that this agency is uniquely qualified for this function as they have expertise in this regard in the commercial market. We met with DCBS on this provision earlier this year, and addressed the only concern we received by including language at the end of the bill allowing the agency to charge a fee for any appeal filing.

Before concluding, we would like to address and clarify the recent CMS decision to approve Oregon's Medicaid rates for 2017. This was not a certification of the rates for actuarial soundness, which is what this bill will address along with transparency in the rate development process. When reviewing the rates for any given year, CMS does not certify the rates as actuarially sound but merely approves the state's contract for the year that include the rate payment exhibits.

We urge the committee to support this very important legislation. Thank you for the time to provide this testimony to you today.

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