SB 233 -2 STAFF MEASURE SUMMARY

Senate Committee On Health Care

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Meeting Dates: 4/4, 4/13

WHAT THE MEASURE DOES:

Codifies definitions for community benefit, eligibility categories, flexible services, related party and social determinants of health. Requires Oregon Health Authority (OHA) to publicly release financial and health care utilization data used to calculate global budgets for coordinated care organizations (CCOs). Requires OHA to use uniform standards when reporting data, publicly. Requires OHA to use specified criteria when establishing a global budget. Allows CCOs to appeal global budget with the Department of Consumer and Business Services (DCBS). Allows CCOs to dispute a global budget by seeking judicial review.

ISSUES DISCUSSED:

- OHA's rate development process for global budgets
- Actuarial soundness, rate setting and certification of global budgets for CCOs
- Reimbursement rates for physical and behavioral health providers that serve Medicaid enrollees

EFFECT OF AMENDMENT:

-2 Defines term, actuarial soundness. Prohibits the Oregon Health Authority from claiming financial and utilization data, among other data sources used by the agency to calculate global budgets as a trade secret. Allows Department of Consumer and Business Services (DCBS) to charge a fee to the non-prevailing party involved in an independent rate appeal process.

REVENUE: No revenue impact.
FISCAL: May have fiscal impact, but no statement yet issued.

BACKGROUND:

Oregon's 16 coordinated care organizations (CCOs) are organizations governed by health care providers, community members and organizations responsible for the financial risks that offer patient-centered health care delivery. CCOs are responsible for the integration and coordination of physical, mental, behavioral, and dental care services for 90 percent of Medicaid beneficiaries enrolled in the Oregon Health Plan (OHP). All 16 CCOs operate within a global budget, which grows at a fixed rate, achieve performance goals, and are held accountable for the Triple Aim. The Triple Aim seeks to improve the individual experience of care, improve the health of populations, and reduce the per-capita costs of care for populations.

On January 12, 2017, Oregon's Medicaid 1115 Demonstration waiver renewal was approved by the Centers for Medicare and Medicaid Services (CMS). The federal waiver preserves the CCOs ability to serve OHP members, advance the coordinated care model and maintains the state's use of the Prioritized List of Health Services. The terms and conditions specified in the waiver describe the methodology for calculating global budgets including medical loss ratios, health-related and flexible services. CMS reviews and certifies rates for Medicaid managed care (i.e. CCOs) to ensure rates are actuarially sound and developed with generally accepted actuarial practices and principles (42 CFR § 438.6). In health care, actuarial soundness and the underlying methodologies refer to the notion that funding is sufficient to pay for projected medical expenditures (e.g. claims) and any related costs (e.g. administrative) incurred by an insurer.

Senate Bill 233 requires the Oregon Health Authority (OHA) to release, publicly, information used to develop individual global budgets for all 16 CCOs.