HB 4018 A STAFF MEASURE SUMMARY

Senate Committee On Health Care

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Meeting Dates: 2/26

WHAT THE MEASURE DOES:

Modifies requirements for coordinated care organizations (CCOs). Establishes meeting requirements for governing bodies of CCOs. Modifies composition of a CCO's governing body. Requires a CCO to spend earnings above specified threshold on services designed to address health disparities and social determinants of health consistent with federal terms and conditions under Section 1115 of the Social Security Act. Modifies composition of a CCO's governing body specific to financial risk entities. Defines "benefit period" and "renewal." Codifies in statute contract provisions for notice of nonrenewal. Specifies that at the end of a benefit period, OHA must notify a CCO of any proposed changes to the terms and conditions of a contract for the next benefit period. Requires a CCO to notify OHA of its refusal to renew a contract within a two-week period after receipt of the proposed contract. Specifies that a CCO's refusal to renew a contract results in termination of existing contract at the end of the benefit period. Grants Director of OHA authority to waive newly created compliance requirements if consistent with administration of the state's Medicaid program. Declares emergency, effective on passage.

ISSUES DISCUSSED:

EFFECT OF AMENDMENT:

No amendment.

BACKGROUND:

Oregon's coordinated care organizations (CCOs) are organizations governed by health care providers, community members, and organizations responsible for the financial risks of providing patient-centered health care services. 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 CCOs operate within a global budget, which grows at a fixed rate, achieves 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.

In 2012, the Oregon Health Authority (OHA) executed five-year contracts with CCOs in conjunction with a Section 1115 federal Medicaid waiver. The contracts require each CCO to have a comprehensive plan that describes its goals and activities for transforming care, a written plan for using health information technology, and to implement a quality improvement plan. The contracts will be renewed in 2019 for the next five-year period (2020-2025).

In 2016, the Oregon Health Policy Board (OHPB) received a request to provide independent policy guidance to the Legislative Assembly and the OHA regarding the future of CCOs in Oregon's health care system. To accomplish this request, the OHPB developed a set recommendations to inform the next phase of Oregon's CCO model (CCO 2.0). The 2017 recommendations include:

- improving fiscal transparency,
- strengthening accountability,
- advancing OHA monitoring and oversight of CCOs,
- enhancing community access and input to CCOs,
- increasing focus on social determinants of health, and
- supporting sustainable costs in Medicaid.

In 2017, the Center for Health Systems Effectiveness released a comprehensive evaluation of Oregon's 2012-2017 Medicaid waiver including an assessment of the CCOs. Findings indicate that CCOs were successful with decreased spending, investing in infrastructure for health care transformation, and improvements in overall quality and access to care.

In January 2018, FamilyCare, Oregon's 2nd largest CCO serving Washington, Multnomah, Clackamas, and Marion counties, ceased, to serve OHP members. As of February 1, 2008, OHP members enrolled in FamilyCare were transitioned to three other CCOs in the Willamette Valley.

House Bill 4018-A modifies requirements for Oregon's 15 coordinated care organizations.