Senate Bill 233

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Oregon Health Authority to make publicly available specified information regarding administration of medical assistance and payments to coordinated care organizations. Specifies criteria and procedures for establishment of global budgets. Provides review by Department of Consumer and Business Services of global budget established by authority.

Requires department to implement procedures for reviewing de novo global budget determination appealed to department by coordinated care organization.

A BILL FOR AN ACT

Relating to coordinated care organizations.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 4 of this 2017 Act are added to and made a part of ORS 413.

SECTION 2. (1) As used in sections 2 and 3 of this 2016 Act:

(a) "Community benefit initiatives" means innovative programs or projects that benefit the health of the community, including but not limited to investments in health care management capabilities and increasing the capacity of the provider networks to serve the health care needs of the community.

(b) "Eligibility categories" means the bases on which members of a coordinated care organization qualify for medical assistance.

(c) "Flexible services" means services that are provided in lieu of or as an adjunct to covered services, such as items or services that address the social determinants of health.

(d) "Related party" means any entity that:

(A) Enters into any type of arrangement with or receives services from a coordinated care organization; and

(B) Is associated with the coordinated care organization by any form of common, privately held ownership, control or investment.

(e) "Social determinants of health" means the conditions in which individuals are born, grow, live, work and age, including but not limited to food, safe housing, economic opportunities, health care, transportation and education.

SECTION 3. (1) It is the intent of the Legislative Assembly that the expenditures of the Oregon Health Authority in administering the medical assistance program and the manner in which the authority establishes global budgets for coordinated care organizations be fully transparent and available to the public at all times.

(2) The authority shall make readily available to the public the following information:

(a) All documentation submitted to the Centers for Medicare and Medicaid Services in seeking federal approval of global budgets for coordinated care organizations.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(b) All documents, financial data and health care utilization data considered by the authority in calculating global budgets for each coordinated care organization, including but not limited to the average utilization of each category of service per 1,000 members of the coordinated care organization, broken down by the geographic regions and eligibility categories of the members.

(c) Each coordinated care organization's related party arrangements.

(3) The authority shall use accurate and uniform standards for measuring and reporting, to the public, the Legislative Assembly and the Centers for Medicare and Medicaid Services, medical loss ratios, administrative costs and earnings.

SECTION 4. (1) The Oregon Health Authority shall determine the health services to be provided by a coordinated care organization prior to establishing the global budget for the coordinated care organization. The determination shall be made no more than once every 12-month period, unless changes are required by federal law.

(2) In establishing the global budget for a coordinated care organization for a calendar year, the authority:

(a) Shall use a single statewide risk score methodology;

(b) Shall include funding for clearly identified flexible services;

(c) May not deduct for quality bonus funds received or quality expenditures made by a coordinated care organization; and

(d) Shall take into account the coordinated care organization's:

(A) Costs incurred, expenditures and reinvestment of savings into:

(i) Providing health services; and

(ii) Providing flexible services, community benefit initiatives and other means of addressing the social determinants of health; and

(B) Financial arrangements with related parties to ensure that the financial arrangements:

(i) Are not significantly different from financial arrangements that would have been entered into in the absence of the relationship between the parties; and

(ii) Do not allow the opportunity for a coordinated care organization to understate its earnings and reserves.

(3) The data reporting requirements established by the authority for coordinated care organizations must be uniform and sufficiently detailed to allow for comparisons of the data between coordinated care organizations and must include the information required by section 3 of this 2017 Act.

(4) The authority shall provide to each coordinated care organization, no later than October 1 of each calendar year, the specific requirements and outcomes that the coordinated care organization must satisfy in order to qualify for incentive payments in the following calendar year.

(5) The authority's actuary must certify the final global budget for each coordinated care organization by rate cell and document the underlying data, assumptions and methodologies used in doing so.

(6) A coordinated care organization may contest the final global budget established for the coordinated care organization by filing an appeal with the Department of Consumer and Business Services in accordance with section 5 of this 2017 Act. The coordinated care organization may seek judicial review in accordance with ORS 183.480 to dispute a global budget

established by the authority following remand by the department under section 5 (2) of this 2017 Act.

SECTION 5. (1) The Department of Consumer and Business Services shall implement procedures, consistent with ORS chapter 183, for the review of an appeal filed by a coordinated care organization under section 4 (6) of this 2017 Act. The review shall be de novo and shall consider, upon the request of the coordinated care organization:

(a) Whether the Oregon Health Authority complied with the provisions of section 4 of this 2017 Act; and

(b) Whether the underlying data, assumptions and methodologies used by the authority's actuary support the global budget established by the authority.

(2) The department shall accept, reject or modify any portion of the global budget or remand the issue to the authority with orders to modify the rate setting process to ensure fairness, equity and a correct result.

(3) The department's determination and orders under subsection (2) of this section are not subject to judicial review.
