FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: SB 204 - B**

Seventy-Sixth Oregon Legislative Assembly – 2011 Regular Session
Legislative Fiscal Office

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Measure Description:
Allows disclosure of identity of person between health care providers and prepaid managed care health services organizations that are paid by state health plan to provide care to person. Requires the Oregon Health Authority to prescribe by rule a uniform payment methodology for hospitals and ambulatory surgical center services that incorporate specified methodologies.

Government Unit(s) Affected:
Oregon Health Authority (OHA)

Summary of Fiscal Impact:
See Analysis

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Analysis:
Section 2 of Senate Bill 204 B-Engrossed allows the disclosure of identity of person between health care providers and prepaid managed care health services organizations that are paid by state health plan to provide care to person. This provision of the bill has no fiscal impact on the Oregon Health Authority.

Sections 3 through 12 of Senate Bill 204 B-Engrossed require the Oregon Health Authority (OHA) to prescribe by rule a uniform payment methodology for hospitals and ambulatory surgical center services (ASCs) that:

1. Incorporates the most recent Medicare payment methodologies established by the Centers for Medicare and Medicaid Services or similar methodologies.
2. Includes payment methodologies for services and equipment that are not fully addressed by Medicare payment methodologies.
3. Allows the use of alternative payment methodologies, including pay-for-performance, bundled payments and capitation

Section 3 (2) of the bill directs OHA to establish and be advised by a work group consisting of providers, purchasers and consumers in developing payment methodologies for hospitals, ASCs and health care service providers.

Type A and B hospitals, and rural critical access hospitals are exempted from this mandate. The Oregon Educators Benefit Board (OEBB) and Public Employees Benefit Board (PEBB), as well as their contracted insurers, are also required to use the same uniform methodology in their payments to hospitals and ambulatory surgery centers. Hospitals or ambulatory surgical centers are mandated to bill and accept as payment in full an amount determined in accordance with the uniform payment prescribed by OHA. Managed care organizations (MCOs) with all OHA agencies, as a condition of contract renewal, must attest on a required form that they comply with all requirements of the bill.

This uniform payment methodology requirement applies to claims by a hospital for reimbursement of services provided by a hospital beginning on January 1, 2012; and to claims by ASC's for reimbursement of services provided on or after January 1, 2013.

Medical Assistance Program (MAP)

If this bill passes, the Medical Assistance Program (MAP) in the Oregon Health Authority will need to communicate with and deliver training to providers to insure a smooth transition. OHA anticipates that the training can be accomplished with current staff using webinars. In order to make the change in methodology required by the bill, OHA will need to license software and modify the Medicaid Management Information System (MMIS). OHA estimates software licensing, and system modification and support costs to be $147,220 for the 2011-13 biennium and $83,636 Total Funds for the 2013-15 biennium. These administrative expenses will qualify for a 50% Federal match. This fiscal assumes that this cost will be covered and deducted from the total savings.

Currently, only FFS Inpatient hospital services are reimbursed on a Diagnosis Related Group (DRG) using Medicare methodology. ASCs are paid an all-inclusive global rate. Outpatient hospital services provided by DRG hospitals are paid at a percent of billed charges based on their cost to charge ratios. ASCs and Outpatient hospital services provided by DRG hospitals differ from Medicare's methodology, and these payments would be impacted by this bill.

This bill would impact 26 Diagnosis Related Group (DRG) hospitals. The hospitals would have to update their payment systems in order to bill and calculate payments for outpatient services. The hospitals would be involved in the workgroup convened by OHA and have input in developing payment methodologies.

The overall impact of this change in methodology for services covered by this bill is a reduction of approximately 7% of all FFS billed outpatient service costs. For managed care clients, this equates to approximately 1.42% of fully capitated health plan (FCHP) capitation payments for outpatient and 3% for inpatient services. The total savings on outpatient services are expected to reach $82.8 million Total Funds ($24.4 million General Fund; $5.9 million Other Funds; $52.5 million Federal Funds) for the nine months of the 2011-13 biennium, and $110.5 million Total Funds ($32.6 million General Fund; $7.8 million Other Funds; $70.1 million Federal Funds) for full 24 months of the 2013-15 biennium.

As a result of lower payments being made to hospitals and MCOs, revenues received by MAP through the hospital provider tax will also decrease. OHA estimates that for the 2011-13 biennium, hospital provider tax will decline by $1.8 million. For the 2013-15 biennium, hospital provider tax will decline by $2.4 million

The pricing above assumes current overall costs will be decreased by 25% for the 2011-13 and 2013-15 biennia. This 25% is made up of a 12% rate reduction and a 13% savings due to improved utilization. If these changes are not in place for the 2011-13 biennium then the savings included in this fiscal will differ.

The Governor's recommended budget and the current proposed co-chairs budget both assume savings in Medical Assistance Programs of $239 million General Fund in the second year of the 2011-13 biennium as a result of transformation of the health care system. The specific cost savings generated by the policy changes in this bill would constitute a portion of those anticipated budget savings.

Oregon Educators Benefit Board (OEBB)

OEBB's consultant estimates that applying the Medicare prospective payment system for hospitals would result in an estimated monthly savings of 1.5% in OEBB medical premium rates resulting in a $12.0 million Other Funds Non-limited savings in medical premium costs. This estimate is based on current 2010-11 premiums and enrollment, with 0% medical inflation added, over a 9 month period. The 2013-15 fiscal impact on OEBB's medical premiums is estimated at a savings of $16.5 million Other Funds Non-limited. This estimate is based on current 2010-11 premiums, with 0% medical inflation added, over a 24 month period.

The Oregon Educators Revolving Fund (ORS 243.884) authorizes the Department of Administrative Services' Oregon Educators Benefit Board (OEBB) to collect employee and employer contributions for pass-thru of benefit premiums to insurance carriers for eligible members. Expenditures made from the Revolving Fund pass-through are Other Funds Non-limited.

Note that this bill has an impact on the insurance premiums provided by OEBB which will impact any educational entity that has mandated or elective coverage under OEBB. This includes school districts, community colleges, education service districts and some charter schools.

Public Employees Benefit Board (PEBB)

PEBB estimates that applying the Medicare prospective payment system for hospitals would result in a 1.25% savings to PEBB self-insured medical premiums. This translates to $10.5 million Other Funds for the 2011-13 biennium. The 2013-15 fiscal impact on PEBB's medical premiums is estimated at a savings of $14.0 million Other Funds Non-limited. Both years' fiscal impacts are based on the assumptions described above for OEBB.

Sections 13 through 19 of the bill authorize Crook, Deschutes and Jefferson Counties to form a Central Oregon Health Council. Adjoining counties are permitted to join council under certain circumstances. The bill specifies the composition of the council, authorizes the council to adopt rules, enter into necessary contracts, apply for and receive grants, hold and dispose of property and take other actions necessary to carry out the activities, services and responsibilities assumed by the council. The council is directed to appoint an advisory committee to guide the council in the performance of its duties. The council is required to conduct a regional health assessment plan and adopt a regional health improvement plan to serve as a strategic population health and health care system service plan for the region served by the council. OHA is required to adopt by rule requirements for the regional health improvement plan by September 1, 2011. The council is required to report to the 2013 and 2015 Legislative Assemblies regarding the implementation of the regional health improvement plan. Sections 13 through 18 of the bill sunsets on January 2, 2016. These provisions of the bill are anticipated to have minimal budgetary impact on the Oregon Health Authority. OHA anticipates using existing staff and resources to adopt rules required by Sections 13 through 19 of the bill. This fiscal assumes participation in the council will have minimal impact on counties, and that any resulting work can be absorbed with existing resources.

The bill contains an emergency clause and takes effect on passage.