BILL SUMMARY
1st Session of the 58th Legislature

Bill No.:	**SB131**
Version:	**FULLPCS1**
Request Number:	**7921**
Author:	**McEntire**
Date:	**4/7/2021**
Impact:	**See analysis below**

Research Analysis

The PCS to SB 131 creates the Oklahomans Caring for Oklahomans Act. The measure requires the Oklahoma Health Care Authority (OHCA) to implement the Oklahomans Caring for Oklahomans Act by developing a program that controls costs and improves health outcomes for Medicaid recipients. The measure directs the OHCA to include the following elements of the program:

- **Prevention** – enrollment and renewal in the program will include a standard baseline risk assessment identifying social health risks
- **Chronic care management** – a plan for chronic care coordination which includes medication therapy management, patient education, interaction between OHCA and beneficiaries, and development of long-term wellness plan
- **Payment reform** – OHCA to develop a transition care management plan, establish value-based payments for providers

The measure requires the OHCA to maximize the sharing of health information among providers to reduce redundancy. Additionally, any program for sharing data will also have the ability to screen for social determinants of health.

Partnerships with tribal nations will be maintained and enhanced under this measure. The measure directs the Oklahoma Health Care Authority to promulgate rules. Lastly, the measure declares an emergency.

Prepared By: Dan Brooks

Fiscal Analysis

PCS to SB 131 Fiscal Impact:

Although SB 131 does not expressly prohibit third party managed care through SoonerSelect, in order to build a state-run managed care delivery system, the agency would require a significant investment that would continue for several years. Simply put, although OHCA operates a limited care management program, OHCA does not currently have the personnel, infrastructure or technology needed to coordinate care at such a level to immediately provide SoonerCare members increased opportunities to access appropriate, quality care and improve poor health outcomes, while still controlling costs via a capitated per-member per-month cost.

This fiscal impact reflects a 5 year investment, however similar investments would be needed every year to continue building and sustaining infrastructure and maintaining a statewide staff. This estimate accounts for additional personnel, upgraded IT systems, data analytics,

infrastructure needs, web portals/tools to reach members, etc. Administrative costs for the agency will increase to around 11% of the budget.

An average of $263,400,000 would be needed every year for at least the first several years. An estimate of needed investment:

Internal MCO - Estimate	Year 1	Year 2	Year 3	Year 4	Year 5
Additional FTE – 1,200	$106,000,000	$106,000,000	$106,000,000	$106,000,000	$106,000,000
Opportunity Cost	$25,000,000	$34,000,000	$27,000,000	$14,000,000	$3,000,000
Lost Premium Tax Revenue	$45,000,000	$58,000,000	$60,000,000	$62,000,000	$64,000,000
Information Technology					
Infrastructure	$25,000,000	$25,000,000	$25,000,000	$25,000,000	$25,000,000
Web Portals/ EDI	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Customer Service	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000
Analytics	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Mobile Application	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
IT Consultants	$3,000,000	$3,000,000	$3,000,000	$500,000	$500,000
	$255,000,000	$277,000,000	$272,000,000	$261,000,000	$252,000,000

This is a more conservative estimate than what was provided by the state's actuary and based off industry standard.
Note: Opportunity cost represents the actuarial identified cost savings achieved by third party MCOs when compared to FFS
Note: this only accounts for the portion of the Medicaid population transitioning to MCO initially (Children / Pregnant Women / Expansion).
Note: Would need to regionalize to have more boots on the ground; community health workers, peer support, housing, etc
Note: This shows a 5 year investment but will continue after as we continue to reinvest in infrastructure and business needs to keep us up to date.

<u>Implementation Impact:</u>
Timing: Due to necessary CMS approvals of IT systems, it is estimated it could take at least 2-3 years to change delivery models and install new IT systems before full implementation of an in-house program could even occur.
Additionally, due to CMS regulations, there are significant limitations on the services a state-run system could provide to Medicaid members:

- The state can only reimburse for Medicaid compensable services, not value-added services that address social determinants of health as a public-private partnership could.

- It can also be a very difficult process for the state to get approval from CMS for in-lieu of services whereas CMS gives MCOs that flexibility.
- The state agency cannot invest back in to the community to improve areas of need, such as education and transportation.
- The state cannot provide member and provider incentives as it would via a public-private partnership model. For example, the contracted health plans have proposed providing incentives for members who reach targeted goals like attending well-child visits.

Specific challenges of SB 131: Even aside from the increased cost and opportunity loss by attempting to provide these services in-house as opposed to a public-private partnership, SB 131 poses several challenges that may adversely impact access to care:

- Requiring legislative approval of benefits over a certain threshold would impair the state's ability to respond quickly to the needs of our members. OHCA currently manages the budget and would seek legislative approval if at any point budgetary needs exceeded appropriations.
- Member incentives would not be possible without specific federal approval and incentive programs for member compliance are difficult to get approved and maintain.
- To provide true care coordination above the limited amount the state does, staffing and technology will be needed. (*See* fiscal impact)

Comparison to SoonerSelect fiscal:
OHCA's goal #1 is to "Purchase cost-effective health care for members by maintaining appropriate rates that strengthen the state's health care infrastructure." Under a risk-based Medicaid managed care approach, this is accomplished through various managed care techniques such as encouraging the use of the most appropriate care setting, implementation of a more robust care management program, a focus on social determinants of health, etc. If the promise of MCO risk-based Medicaid managed care to deliver increased cost efficiency and effectiveness is to be realized, benefit savings under managed care must be greater than the non-benefit expense component for MCO administration and underwriting gain. In other words, MCOs must be able to live within the current OHCA budget including their administrative cost. The goal is higher quality and better outcomes for members, budget stability, and cost savings or at a minimum cost controls that limit growth.
With the current program, 100% of the risk is on the state and with SoonerSelect much of the risk is transferred to the MCOs. Below shows the percentage change in growth over the past 5 years.

Growth 16-17	Growth 17-18	Growth 18-19	Growth 19-'20	2020 Actuals - 2021 Budget
4.7%	2.0%	5.5%	1.9%	8.4%

Risk Corridors

With the movement to risk-based managed care for several population groups effective October 1, 2021, as well as the addition of Expansion Adults who also become part of risk-based managed care October 1, 2021, OHCA chose to mitigate risk for the State, CMS, and the MCOs in order to enhance program stability for the initial rating period October 1, 2021 through June 30, 2022. This goal is accomplished via incorporation of a minimum/maximum Medical Loss

Ratio (MLR) with a risk corridor between those two points. The approach is two-sided, and symmetric meaning it protects the state financially from the potential of exorbitant MCOs profits and protects against future program instability.

MLR/Corridor implementation and remittance/payment

The MCO's MLR calculation will be consistent with 42 CFR § 438.8 and applicable CMS sub-regulatory guidance, excluding directed payments. Remittance/payment (if any) is based upon how the MCO's MLR compares to the final priced-for MLR. Depending upon that comparison, after the +/-2% band where the MCO retains 100% responsibility, the actual MLR determines the cumulative responsibility of the MCO or OHCA/CMS, to be applied against the applicable capitation dollars. For example, an MCO 80% actual MLR would generate a 5% (to the 85% minimum), plus 50% share of the next band, cumulative remittance impact.

The following table has been provided for illustrative purposes. It uses a priced-for MLR of 90% (100% - 8.5% assumed MCO Administrative Expense - 1.5% assumed MCO Underwriting Gain = 90%). The final priced-for MLR for the rating period is subject to actual member month mix given varying rate cell administrative loads. The corridor will always be symmetric. The 85% minimum MLR will not change and neither will the share factors. However, given the actual MCO priced-for MLR, the 88%, 92%, and 95% will be adjusted to provide a symmetrical corridor. Directed payments and their associated non-benefit loads are excluded from the remittance calculation as they are a capitation rate separate payment term. The MLR calculation will be done across all population groups except a separate calculation will be done for the Medicaid Expansion population for any remittance federal match claiming purposes.

Medical Loss Ratio Corridor	MCO Share of Gain/Loss in the Corridor	OHCA/CMS Share of the Gain/Loss in the Corridor
MLR of less than 85%	0%	100%
MLR equal to or greater than 85% and less than 88%	50%	50%
MLR equal to or greater than 88% and less than 92%	100%	0%
MLR equal to or greater than 92% and less than 95%	50%	50%
MLR equal to or greater than 95%	0%	100%

An important note, the state will never be funding any portion of MCO profits, only mitigating losses (if necessary) to stand up a sustainable program. Also, OHCA will be able to share in profits which creates a ceiling for MCO profit. This is very attractive with a new expansion population and the tail end of the PHE where utilization hast still not normalized. A few scenarios to consider (with some broad assumptions):

1. MLR 85% - OHCA/CMS would receive $30 million, the plans anticipated net income (after administrative expense) would be approximately $100 million.
2. MLR 88% - OHCA/CMS would pay $0, the plans anticipated net income (after administrative expense) would be approximately $70 million.

3. MLR 90% - OHCA/CMS would pay $0, the plans anticipated net income (after administrative expense) would be approximately $30 million.
4. MLR 92% - OHCA/CMS would pay $0, the plans anticipated net loss (after administrative expense) would be approximately $10 million.
5. MLR 95% - OHCA/CMS would pay $30 million, the plans anticipated net loss (after administrative expense) would be approximately $40 million.

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Other Considerations

None.