LC 36
2016 Regular Session
1/12/16 (LHF/ps)

D R A F T

SUMMARY

Modifies requirements regarding coordinated care organization contracts and for establishing global budgets and required services. Establishes judicial review procedure for coordinated care organization to appeal order of Oregon Health Authority terminating contract or reducing global budget.

Requires authority to maintain publicly accessible log of open records requests related to global budgets and to post to website communications between authority and Centers for Medicare and Medicaid Services.

Allows member of coordinated care organization to transfer to different coordinated care organization no more than once every six months.

Requires authority to reimburse coordinated care organization on fee-for-service basis for treatment of complications arising from home birth.

Becomes operative January 1, 2017.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 411.404, 414.067, 414.631, 414.645, 414.652 and 414.653; and declaring an emergency.

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

SECTION 1. (1) As used in this section:

(a) "Eligibility category" means the basis on which a member of a coordinated care organization qualifies for medical assistance.

(b) "Social determinants of health" means the conditions, such as having access to resources to meet an individual's need for food, safe housing, economic opportunities, health care and education, in which individuals are born, grow, live, work and age.

(2) In establishing the global budget to be paid to a coordinated care organization for a calendar year, the Oregon Health Authority shall:

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.

(a) Take into account the costs and expenditures incurred by the coordinated care organization in addressing the social determinants of health for its members;

(b) Apply risk models uniformly statewide without variation by geographic region;

(c) Take into account profits earned by the coordinated care organization and the contractors and subcontractors of the organization;

(d) Take into account all medical and nonmedical services that a coordinated care organization must provide to its members during a calendar year; and

(e) Take into account the coordinated care organization's reinvestment of excess reserves and profits in order to address the social determinants of health.

(3) The data reporting requirements established by the authority for coordinated care organizations must be uniform to allow for comparisons of the data between coordinated care organizations and must include the information required by subsection (4) of this section.

(4) Not later than July 1 of each calendar year, the authority shall make readily available to the public:

(a) All financial data and health care utilization data considered by the authority in establishing the global budget of 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;

(b) The records of all financial transactions between each coordinated care organization and its contractors and subcontractors, other than individual health care providers, including the amount of each transaction, the parties to the transaction and an explanation of how the authority considered the transaction in establishing a global budget; and

(c) The profits earned by each coordinated care organization and by each of the contractors and subcontractors of the coordinated care organization.

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

SECTION 2. The Oregon Health Authority shall submit to the Centers for Medicare and Medicaid Services amendments to the state Medicaid plan or to this state's demonstration project as necessary to implement the provisions of section 1 of this 2016 Act on and after January 1, 2017.

SECTION 3. Notwithstanding ORS chapter 183, a coordinated care organization may seek judicial review in the circuit court of the county where the organization is located of any order of the Oregon Health Authority proposing to terminate the contract of the coordinated care organization or to reduce the organization's global budget. The court may grant injunctive relief to the coordinated care organization to enjoin the termination of the organization's contract, or the reduction of the organization's global budget, pending the resolution of the appeal. Judicial review shall be as provided in ORS 183.484, 183.486, 183.490, 183.497 and 183.500 for judicial review of an order in other than a contested case.

SECTION 4. (1) The Oregon Health Authority shall maintain a log of all of requests the authority receives under ORS 192.410 to 192.505 for records related to the establishment of global budgets. The log must contain a summary of each request, the response of the authority and the date of the authority's response. The authority shall make the log readily available to the public.

(2) The authority shall post to the authority's website, in an easily accessible location, all written communications, and summaries of all

oral communications, between the authority and the Centers for Medicare and Medicaid Services. A communication must be posted to the website no later than 24 hours after the authority sends or receives the communication.

SECTION 5. ORS 414.067 is amended to read:

414.067. (1) If the Oregon Health Authority or the Department of Human Services requires a coordinated care organization to provide a service, paid for out of the organization's global budget, that was previously reimbursed by the authority or the department on a fee-for-service basis, the authority or the department must provide the organization with a statement of the costs incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service.

(2) If the authority or the department requires a coordinated care organization to assume the cost of a service as described in subsection (1) of this section, the authority or the department shall report to the Legislative Assembly, not later than February 1 of the following year, a statement of the increased cost to the coordinated care organization of providing the service, calculated as the average annual cost incurred by the authority or the department in reimbursing the service during the three-year period prior to the organization's assumption of the cost of the service.

(3) The authority may not add service requirements under subsection (1) of this section during a calendar year to the extent that the total cost of all the added requirements exceeds one percent of a coordinated care organization's global budget. The services for which the costs exceed one percent of the coordinated care organization's global budget may be added during the following calendar year, subject to ORS 414.652 and section 1 of this 2016 Act.

SECTION 6. ORS 414.645 is amended to read:

414.645. (1) A coordinated care organization that contracts with the Oregon Health Authority must maintain a network of providers sufficient in

numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(2) **Upon request,** a member may transfer from one organization to another organization [*no more than*] once during [*each enrollment*] **a six-month** period.

SECTION 7. ORS 414.652 is amended to read:

414.652. (1) A contract entered into between the Oregon Health Authority and a coordinated care organization under ORS 414.625 (1):

(a) Shall be for a term of five years;

(b) Except as provided in subsection (3) of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated if a coordinated care organization fails to meet outcome and quality measures [*specified in the contract*] **adopted under ORS 414.638, substantially fails to meet criteria adopted by the authority under ORS 414.625** or is otherwise in breach of the contract.

(2) [*This section does not prohibit*] The authority [*from allowing*] **shall allow** a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures**,** [*specified in the contract*] **or criteria adopted by the authority under ORS 414.625,** prior to the termination of the contract.

(3) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

(a) The authority and the coordinated care organization mutually agree to amend the contract; or

(b) Amendments are necessitated by changes in federal or state law.

(4) The authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts, or to contracts to be renewed, between the authority and the coordinated care organization.

(5) The authority may amend a contract with a coordinated care

organization in order to adjust the global budget to be paid to the coordinated care organization during the next calendar year only if the authority:

(a) Has provided the coordinated care organization, not later than August 1, with an opportunity to review and respond to the amendments; and

(b) Has submitted the amendments, not later than September 1, to the Centers for Medicare and Medicaid Services for review.

(6) A global budget for a calendar year:

(a) Must be established by the authority prospectively and may not be reduced retroactively;

(b) May be reduced during a calendar year only in response to a decrease in the number of members enrolled in a coordinated care organization; and

(c) May not be reduced for the following calendar year if the authority fails to comply with subsection (5) of this section.

(7) A coordinated care organization make seek judicial review, in accordance with section 3 of this 2016 Act, if the authority proposes to decrease the organization's global budget. If the organization seeks judicial review, the organization's global budget must remain the same until the court has made a determination as to whether the revised global budget meets the requirements of section 1 of this 2016 Act. The authority may not terminate the contract of a coordinated care organization based on the organization's refusal to agree to a decrease in the organization's global budget while the organization seeks judicial review.

(8) The authority may renew a contract with a coordinated care organization when the previous five-year term expires only if the coordinated care organization is meeting at least 80 percent of the outcome and quality measures adopted under ORS 414.638.

SECTION 8. ORS 414.653 is amended to read:

414.653. (1) The Oregon Health Authority shall [*encourage*] **require** coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes and behavioral health homes.

(2) The authority shall [*encourage*] **require** coordinated care organizations to utilize alternative payment methodologies [*that*] **to** move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

(3) The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

(4) If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

(5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments

to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

(6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

SECTION 9. ORS 414.631 is amended to read:

414.631. (1) Except as provided in subsections (2), (3), (4) and (5) of this section and ORS 414.632 (2), a person who is eligible for or receiving health services must be enrolled in a coordinated care organization to receive the health services for which the person is eligible. For purposes of this subsection, Medicaid-funded long term care services do not constitute health services.

(2) Subsections (1) and (4) of this section do not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary;

(c) An individual described in ORS 414.632 (2) who is dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly; [*and*]

(d) A person whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs;

(E) A person receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1); and

(F) A person with major medical coverage[.]**; and**

(e) A pregnant woman who elects to have a home birth. If the woman enrolls in a coordinated care organization following the home birth, the authority shall reimburse the coordinated care organization, on a fee-for-service basis, the cost of services provided to treat any complications with respect to the mother or child arising from the home birth.

(3) Subsection (1) of this section does not apply to a person who resides in an area that is not served by a coordinated care organization or where the organization's provider network is inadequate.

(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.

(5) As used in this section[*,*]**:**

(a) "American Indian and Alaskan Native beneficiary" means:

[*(a)*] **(A)** A member of a federally recognized Indian tribe;

[*(b)*] **(B)** An individual who resides in an urban center and:

[*(A)*] **(i)** Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups whose recognition was terminated since 1940 and those recognized now or in the future by the state in which the member resides, or who is a descendant in the first or second degree of such a member;

[*(B)*] **(ii)** Is an Eskimo or Aleut or other Alaskan Native; or

[*(C)*] **(iii)** Is determined to be an Indian under regulations promulgated by the United States Secretary of the Interior;

[*(c)*] **(C)** A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose; or

[*(d)*] **(D)** An individual who is considered by the United States Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaskan Native.

(b) "Home birth" means labor and delivery, supervised by a direct entry midwife licensed under ORS 687.405 to 687.495, that occurs in a setting outside of a hospital.

SECTION 10. ORS 411.404 is amended to read:

411.404. (1) The Department of Human Services or the Oregon Health Authority shall determine eligibility for medical assistance according to criteria prescribed by rule and in accordance with the requirements for securing federal financial participation in the costs of administering Titles XIX and XXI of the Social Security Act. **The department and the authority shall complete the determination of eligibility on 99 percent of all applications and renewals of eligibility no later than 30 days after the initial and renewal applications are received by the department or the authority.**

(2) Rules adopted under this section may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as the person's home.

SECTION 11. Sections 1, 3 and 4 of this 2016 Act and the amendments to ORS 411.404, 414.067, 414.631, 414.645, 414.652 and 414.653 by sections 5 to 10 of this 2016 Act become operative on January 1, 2017.

SECTION 12. This 2016 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2016 Act takes effect on its passage.