House Bill 4012

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of the House Interim Committee on Health Care)

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.**

Provides legislative approval of Oregon Health Authority proposals for coordinated care organizations. Requires authority to report quarterly to legislative committees on implementation of coordinated care organization model of health care delivery. Authorizes sharing and use of information between Department of Consumer and Business Services and authority for specified purposes. Prohibits discrimination against types of providers by coordinated care organizations and specified managed care organizations.

Makes technical corrections.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care delivery; creating new provisions; amending ORS 414.033, 414.632, 414.635, 414.740 and 416.540 and sections 14, 62, 63 and 64, chapter 602, Oregon Laws 2011; and declaring an emergency.

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

LEGISLATIVE APPROVAL OF COORDINATED CARE ORGANIZATION PROPOSAL

SECTION 1. The Legislative Assembly approves the proposals presented by the Oregon Health Authority as required by section 13, chapter 602, Oregon Laws 2011.

SECTION 2. Section 14, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 14. (1) Notwithstanding ORS [*414.725 and 414.737*] **414.631 and 414.651**, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under [*sections 4, 6, 8, 10 and 12 of this 2011 Act and*] ORS 414.153, **414.625, 414.635, 414.638, 414.651, 414.655, 414.679,** 414.712, [*414.725,*] 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.

(3) The authority may amend contracts that are in place on [*the effective date of this 2011 Act*] **July 1, 2011,** to allow prepaid managed care health services organizations that meet the criteria [*approved by the Legislative Assembly under section 13 of this 2011 Act*] **adopted by the authority under ORS 414.625** to become coordinated care organizations.

(4) The authority shall continue to renew the contracts of prepaid managed care health services

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.

organizations that have a contract with the authority on [*the effective date of this 2011 Act*] **July 1, 2011,** until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.

(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.

(6) Notwithstanding [*sections 4 (1)(g) and 6 (2) of this 2011 Act*] **ORS 414.625 (1)(g) and 414.655 (2)**, the authority shall allow for a period of transition to the full adoption of health information technology by coordinated care organizations and patient centered primary care homes. The authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology.

SECTION 3. Section 62, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 62. [*(1)*] The Oregon Health Authority may not implement any [*provisions of this 2011 Act that require*] **provision of chapter 602, Oregon Laws 2011, that requires** federal approval**,** or that [*require*] **requires** federal approval to receive federal financial participation**,** until the authority has received the **federal** approval.

[*(2) Until the authority has received the approval of the Legislative Assembly under section 13 of this 2011 Act, the authority may not:*]

[*(a) Adopt by rule the qualification criteria for a coordinated care organization under section 4 of this 2011 Act or contract with a coordinated care organization;*]

[*(b) Adopt by rule a global budgeting process or establish global budgets for coordinated care organizations; or*]

[*(c) Implement a process for financial reporting by coordinated care organizations or establish financial reporting requirements under ORS 414.725 (1)(c).*]

SECTION 4. Section 63, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 63. The amendments to [*section 8 of this 2011 Act*] **ORS 414.635** by section 9 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** become operative [*January 1, 2014*] **on the effective date of this 2012 Act**.

SECTION 5. ORS 414.635, as amended by section 9, chapter 602, Oregon Laws 2011, is amended to read:

414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

(a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery

system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

(3) Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7) The authority shall maintain the process[*, approved by the Legislative Assembly,*] for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator.

(8) A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.

IMPLEMENTATION OF OREGON INTEGRATED AND COORDINATED CARE DELIVERY SYSTEM

SECTION 6. (1) The Department of Consumer and Business Services and the Oregon Health Authority may enter into agreements governing the disclosure of information reported to the department by insurers with certificates of authority to transact insurance in this state.

(2) The authority may use information disclosed under subsection (1) of this section for the purpose of carrying out ORS 414.625, 414.635, 414.638, 414.645 and 414.651.

SECTION 7. Section 8 of this 2012 Act is added to and made a part of ORS chapter 414.

SECTION 8. (1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. A plan or organization must give written notice containing the reasons for its action if the plan or organization declines the participation of any provider or group of providers.

(2) Subsection (1) of this section does not:

(a) Require a plan or organization to contract with more providers than are necessary to meet the needs of its members;

(b) Preclude the plan or organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or

(c) Preclude the plan or organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the plan's or organization's responsibilities to its members.

SECTION 9. Section 8 of this 2012 Act is amended to read:

Sec. 8. (1) A [*fully capitated health plan, physician care organization or*] coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. [*A plan or*] **An** organization must give written notice containing the reasons for its action if the [*plan or*] organization declines the participation of any provider or group of providers.

(2) Subsection (1) of this section does not:

(a) Require [*a plan or*] **an** organization to contract with more providers than are necessary to meet the needs of its members;

(b) Preclude the [*plan or*] organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or

(c) Preclude the [*plan or*] organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the [*plan's or*] organization's responsibilities to its members.

SECTION 10. The amendments to section 8 of this 2012 Act by section 9 of this 2012 Act become operative July 1, 2017.

SECTION 11. In each calendar quarter, the Oregon Health Authority shall report to the appropriate committees or interim committees of the Legislative Assembly on the implementation of the Oregon Integrated and Coordinated Care Delivery System.

SECTION 12. Section 11 of this 2012 Act is repealed July 1, 2017.

TECHNICAL CORRECTIONS AND CONFORMING AMENDMENTS

SECTION 13. Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 64. (1) ORS 414.705 is repealed.

(2) Sections 13[*, 14*] and 17 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** are repealed January 2, 2014.

(3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

(4) Section 14, chapter 602, Oregon Laws 2011, as amended by section 2 of this 2012 Act, is repealed July 1, 2017.

SECTION 14. ORS 414.033 is amended to read:

414.033. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from[,] the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project for:

(a) Providing medical assistance to individuals who are dually eligible for Medicare and Medicaid using **global or** alternative payment methodologies or integrated and coordinated health care and services; or

(b) Evaluating service delivery systems.

SECTION 15. ORS 414.632 is amended to read:

414.632. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services [*under section 17, chapter 602, Oregon Laws 2011*], coordinated care organizations that meet the criteria adopted under ORS 414.625 are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) [*A*] Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved.

SECTION 16. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS [*414.705 (1)(b)*] **414.025 (8)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS [*414.705 (1)(k)*] **414.025 (8)(k)** and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services under ORS 414.631, 414.651 and 414.688 to 414.750.

SECTION 17. ORS 416.540 is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise.

(2) The lien does not attach to the amount of any judgment, settlement or compromise to the extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment, settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by the recipient on account of the personal injuries for which the recipient had a claim.

(3) The authority may assign the lien described in subsection (1) of this section to a prepaid managed care health services organization or a coordinated care organization for medical costs incurred by a recipient:

(a) During a period for which the authority paid a capitation or enrollment fee or a payment using [*an alternative*] **a global** payment methodology; and

(b) On account of the personal injury for which the recipient had a claim.

(4) A prepaid managed care health services organization or a coordinated care organization to which the authority has assigned a lien shall notify the authority no later than 10 days after filing notice of a lien.

(5) For the purposes of ORS 416.510 to 416.610, the authority may designate the prepaid managed care health services organization or the coordinated care organization to which a lien is assigned as its designee.

(6) If the authority and a prepaid managed care health services organization or a coordinated care organization both have filed a lien, the authority's lien shall be satisfied first.

SECTION 18. ORS 414.631, 414.651 and 414.688 to 414.750 are added to and made a part of ORS chapter 414.

CAPTIONS

SECTION 19. The unit captions used in this 2012 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2012 Act.

EMERGENCY CLAUSE

SECTION 20. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.