HB 4013-1
(LC 160)
2/19/14 (LHF/ps)

PROPOSED AMENDMENTS TO
HOUSE BILL 4013

On page 1 of the printed bill, line 2, after the first semicolon insert "creating new provisions;" and after "ORS" insert "414.653,".

After line 3, insert:

"**ELECTRONIC TRANSMISSION OF SCHEDULE II DRUG PRESCRIPTIONS**".

On page 2, after line 37, insert:

"**STEP THERAPY**

"SECTION 3. Section 4 of this 2014 Act is added to and made a part of the Insurance Code.

"SECTION 4. (1) As used in this section:

"(a) 'Health care coverage plan' includes:

"(A) A health benefit plan, as defined in ORS 743.730;

"(B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies;

"(C) A medical services contract, as defined in ORS 743.801;

"(D) A multiple employer welfare arrangement, as defined in ORS 750.301;

"(E) A contract or agreement with a health care service contractor, as defined in ORS 750.005, or a preferred provider organization;

"(F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator that pays prescription drug claims;

"(G) A coordinated care organization, as defined in ORS 414.025; and

"(H) An accident insurance policy or any other insurance contract providing reimbursement for the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies.

"(b) 'Step therapy' means a drug protocol for which a health care coverage plan will cover a prescribed drug only if the patient has first tried a drug or series of drugs specified by the health care coverage plan.

"(2) A health care coverage plan that requires step therapy shall make easily accessible to prescribing practitioners, clear explanations of:

"(a) The clinical criteria for each step therapy protocol;

"(b) The procedure by which a practitioner may provide to the plan a medical rationale supporting the practitioner's determination that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and

"(c) The specific documentation, if any, required for the plan to determine the appropriateness of step therapy for a particular patient.

"SECTION 5. ORS 414.653 is amended to read:

"414.653. (1) The Oregon Health Authority shall encourage 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.

"(2) The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that 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).

"**(7) A coordinated care organization must make easily accessible to any provider that contracts with or is employed by the organization explanations of the criteria, procedures and documentation requirements for step therapy as described in section 4 (2) of this 2014 Act.**

"UNIT CAPTIONS

"<u>SECTION 6.</u> The unit captions used in this 2014 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 2014 Act.

"OPERATIVE DATE

"SECTION 7. Section 4 of this 2014 Act and the amendments to ORS 414.653 by section 5 of this 2014 Act become operative January 1, 2015.

"**EMERGENCY CLAUSE**".

In line 38, delete "3" and insert "8".
