78th OREGON LEGISLATIVE ASSEMBLY--2015 Regular Session

House Bill 2200

Sponsored by Representative GREENLICK (Presession filed.)

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.**

Corrects references, removes references to repealed statutes and repeals statute that conflicts with another statute.

1 **A BILL FOR AN ACT**

2 Relating to the Oregon Integrated and Coordinated Health Care Delivery System; amending ORS
3 414.325, 414.329, 414.625, 414.712, 414.735, 414.738, 414.739, 414.740, 414.743 and 414.745; and re-
4 pealing ORS 414.727.

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

6 **SECTION 1.** ORS 414.325 is amended to read:

7 414.325. (1) As used in this section:

8 (a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS
9 689.005.

10 (b) "Mental health drug" means a type of legend drug defined by the Oregon Health Authority
11 by rule that includes, but is not limited to:

12 (A) Therapeutic class 7 ataractics-tranquilizers; and

13 (B) Therapeutic class 11 psychostimulants-antidepressants.

14 (c) "Urgent medical condition" means a medical condition that arises suddenly, is not life-
15 threatening and requires prompt treatment to avoid the development of more serious medical prob-
16 lems.

17 (2) The authority shall reimburse the cost of a legend drug prescribed for a recipient of medical
18 assistance only if the legend drug:

19 (a) Is on the drug list of the Practitioner-Managed Prescription Drug Plan adopted under ORS
20 414.334;

21 (b) Is in a therapeutic class of nonsedating antihistamines and nasal inhalers, as defined by the
22 authority by rule, and is prescribed by an allergist for the treatment of:

23 (A) Asthma;

24 (B) Sinusitis;

25 (C) Rhinitis; or

26 (D) Allergies; or

27 (c) Is prescribed and dispensed under this chapter by a licensed practitioner at a rural health
28 clinic for an urgent medical condition and:

29 (A) There is no pharmacy within 15 miles of the clinic;

30 (B) The prescription is dispensed for a patient outside of the normal business hours of any
31 pharmacy within 15 miles of the clinic; or

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.

(C) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(3) The authority shall pay only for drugs in the generic form unless an exception has been granted by the authority through the prior authorization process adopted by the authority under subsection (4) of this section.

(4) Notwithstanding subsection (2) of this section, the authority shall provide reimbursement for a legend drug that does not meet the criteria in subsection (2) of this section if:

(a) It is a mental health drug.

(b) The authority grants approval through a prior authorization process adopted by the authority by rule.

(c) The prescriber contacts the authority requesting prior authorization and the authority or its agent fails to respond to the telephone call or to a prescriber's request made by electronic mail within 24 hours.

(d) After consultation with the authority or its agent, the prescriber, in the prescriber's professional judgment, determines that the drug is medically appropriate.

(e) The original prescription was written prior to July 28, 2009, or the request is for a refill of a prescription for:

(A) The treatment of seizures, cancer, HIV or AIDS; or

(B) An immunosuppressant.

(f) It is a drug in a class not evaluated for the Practitioner-Managed Prescription Drug Plan adopted under ORS 414.334.

(5) Notwithstanding subsections (1) to (4) of this section, the authority is authorized to:

(a) Withhold payment for a legend drug when federal financial participation is not available;

(b) Require prior authorization of payment for drugs that the authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession; and

(c) Withhold payment for a legend drug that is not a funded health service on the prioritized list of health services established by the Health Evidence Review Commission under ORS [*414.720*] **414.690**.

(6) Notwithstanding ORS 414.334, the authority may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(7) Notwithstanding subsection (3) of this section, the authority may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(8)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

(9) The authority shall appoint an advisory committee in accordance with ORS 183.333 for any rulemaking conducted pursuant to this section.

SECTION 2. ORS 414.329 is amended to read:

414.329. (1) Notwithstanding ORS [*414.631, 414.651 and 414.688 to 414.745*] **414.690**, the Oregon Health Authority shall adopt rules modifying the prescription drug benefits for persons who are el-

igible for Medicare Part D prescription drug coverage and who receive prescription drug benefits under the state medical assistance program or Title XIX of the Social Security Act. The rules shall include but need not be limited to:

(a) Identification of the Part D classes of drugs for which federal financial participation is not available and that are not covered classes of drugs;

(b) Identification of the Part D classes of drugs for which federal financial participation is not available and that are covered classes of drugs;

(c) Identification of the classes of drugs not covered under Medicare Part D prescription drug coverage for which federal financial participation is available and that are covered classes of drugs; and

(d) Cost-sharing obligations related to the provision of Part D classes of drugs for which federal financial participation is not available.

(2) As used in this section, "covered classes of drugs" means classes of prescription drugs provided to persons eligible for prescription drug coverage under the state medical assistance program or Title XIX of the Social Security Act.

SECTION 3. ORS 414.625 is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must include, but are not limited to, the coordinated care organization's demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget.

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes or other models that support patient centered primary care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established by the authority under ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.635.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.627.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures[,] **and** objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

(m) Each coordinated care organization uses best practices in the management of finances,

contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 442.210 (3).

(o) Each coordinated care organization has a governing body that includes:

(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;

(B) The major components of the health care delivery system;

(C) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and

(ii) A mental health or chemical dependency treatment provider;

(D) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(E) At least one member of the community advisory council.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 4. ORS 414.712 is amended to read:

414.712. The Oregon Health Authority shall provide health services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** to eligible persons who are determined eligible for medical assistance as defined in ORS 414.025. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for individuals who receive medical assistance under ORS 411.706 and for recipients who are members of coordinated care organizations. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a recipient's advocate whenever the recipient or a physician or other medical personnel serving the recipient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider or a coordinated care organization. Recipients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor and the Oregon Health Policy Board in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and access to or quality of care provided to eligible persons by health care providers and coordinated care organizations.

(2) Case management services in each health care provider organization or coordinated care organization for those individuals who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of individuals who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist recipients served by the organization with the coordination of the recipient's health services at the reasonable request of the recipient or a physician or other medical personnel serving the recipient. Recipients shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a recipient's medical needs require swift resolution of a dispute. An ombudsman described in subsection (1) of this section may not act as the recipient's representative during any grievance or hearing process.

SECTION 5. ORS 414.735 is amended to read:

414.735. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law may not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement may not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important.

(3) The Oregon Health Authority shall obtain the approval of the Legislative Assembly, or the Emergency Board if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

(4) This section does not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

SECTION 6. ORS 414.738 is amended to read:

414.738. (1) If the Oregon Health Authority has not been able to contract with the fully capitated health plan or plans in a designated area, the authority may contract with a physician care organization in the designated area.

(2) The Office for Oregon Health Policy and Research shall develop criteria that the authority shall consider when determining the circumstances under which the authority may contract with a physician care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The physician care organization must be able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health services provided to the enrollee;

(b) The contract with a physician care organization does not threaten the financial viability of other fully capitated health plans in the designated area; and

1 (c) The contract with a physician care organization must be consistent with the legislative in-
2 tent of using prepaid managed care health services organizations to provide services under [*ORS*
3 *414.631, 414.651 and 414.688 to 414.745*] **this chapter**.
4 **SECTION 7.** ORS 414.739 is amended to read:
5 414.739. (1) A fully capitated health plan may apply to the Oregon Health Authority to contract
6 with the authority as a physician care organization rather than as a fully capitated health plan to
7 provide services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter**.
8 (2) The Office for Oregon Health Policy and Research shall develop the criteria that the au-
9 thority must use to determine the circumstances under which the authority may accept an applica-
10 tion by a fully capitated health plan to contract as a physician care organization. The criteria
11 developed by the office shall include but not be limited to the following:
12 (a) The fully capitated health plan must show documented losses due to hospital risk and must
13 show due diligence in managing those risks; and
14 (b) Contracting as a physician care organization is financially viable for the fully capitated
15 health plan.
16 **SECTION 8.** ORS 414.740 is amended to read:
17 414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under
18 ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this
19 state and that has been issued a certificate of authority by the Department of Consumer and Busi-
20 ness Services as a health care service contractor to provide health services as described in ORS
21 414.025 (7)(b), (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid
22 capitated basis to provide the health services described in ORS 414.025 (7)(k) and (L). The authority
23 may accept financial contributions from any public or private entity to help implement and admin-
24 ister the contract. The authority shall seek federal matching funds for any financial contributions
25 received under this section.
26 (2) In a designated area, in addition to the contract described in subsection (1) of this section,
27 the authority shall contract with prepaid managed care health services organizations to provide
28 health services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter**.
29 **SECTION 9.** ORS 414.743 is amended to read:
30 414.743. (1) Except as provided in subsection (2) of this section, a coordinated care organization
31 that does not have a contract with a hospital to provide inpatient or outpatient hospital services
32 under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** must, using Medicare payment
33 methodology, reimburse the noncontracting hospital for services provided to an enrollee of the plan
34 at a rate no less than a percentage of the Medicare reimbursement rate for those services. The
35 percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate
36 under this subsection is equal to four percentage points less than the percentage of Medicare cost
37 used by the authority in calculating the base hospital capitation payment to the plan, excluding any
38 supplemental payments.
39 (2)(a) If a coordinated care organization does not have a contract with a hospital, and the hos-
40 pital provides less than 10 percent of the hospital admissions and outpatient hospital services to
41 enrollees of the organization, the percentage of the Medicare reimbursement rate that is used to
42 determine the reimbursement rate under subsection (1) of this section is equal to two percentage
43 points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating
44 the base hospital capitation payment to the organization, excluding any supplemental payments.
45 (b) This subsection is not intended to discourage a coordinated care organization and a hospital

from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to enrollees of the organization.

(3) A hospital that does not have a contract with a coordinated care organization to provide inpatient or outpatient hospital services under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** must accept as payment in full for hospital services the rates described in subsections (1) and (2) of this section.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(5) The Oregon Health Authority shall adopt rules to implement and administer this section.

SECTION 10. ORS 414.745 is amended to read:

414.745. Any health care provider or plan contracting to provide services to the eligible population under [*ORS 414.631, 414.651 and 414.688 to 414.745*] **this chapter** shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to ORS 414.735.

SECTION 11. ORS 414.727 is repealed.