SB 1531-4
(LC 36)
2/5/16 (LHF/ps)

Requested by Senator BATES

PROPOSED AMENDMENTS TO

SENATE BILL 1531

On page 1 of the printed bill, line 2, delete "414.067," and delete "414.645,".

In line 3, delete "414.652 and 414.653" and insert "and 414.652".

Delete lines 5 through 25 and delete pages 2 through 6 and insert:

"SECTION 1. Sections 2 and 4 of this 2016 Act are added to and made a part of ORS chapter 414.

"SECTION 2. (1) As used in this section:

"(a) 'Community benefit initiatives' means innovative programs or projects that benefit the health of the community, including but not limited to investments in health care management capabilities and increasing the capacity of the provider networks to serve the health care needs of the community.

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

"(c) 'Flexible services' means services that are provided in lieu of or as an adjunct to covered services, such as items or services that address the social determinants of health.

"(d) 'Related party' means any entity that:

"(A) Enters into any type of arrangement with or receives services from a coordinated care organization; and

"(B) Is associated with the coordinated care organization by any

form of common, privately held ownership, control or investment.

"(e) 'Social determinants of health' means the conditions in which individuals are born, grow, live, work and age, including but not limited to food, safe housing, economic opportunities, health care, transportation and education.

"(2) The Oregon Health Authority shall determine the health services to be provided by a coordinated care organization prior to establishing the global budget for the coordinated care organization. The determination shall be made no more than once every 12-month period, unless changes are required by federal law.

"(3) In establishing the global budget for a coordinated care organization for a calendar year, the authority shall take into account the coordinated care organization's:

"(a) Costs incurred, expenditures and reinvestment of savings into:

"(A) Providing health services; and

"(B) Providing flexible services, community benefit initiatives and other means of addressing the social determinants of health; and

"(b) Financial arrangements with related parties to ensure that the financial arrangements:

"(A) Are not significantly different from financial arrangements that would have been entered into in the absence of the relationship between the parties; and

"(B) Do not allow the opportunity for a coordinated care organization to understate its earnings and reserves.

"(4) The data reporting requirements established by the authority for coordinated care organizations must be uniform and sufficiently detailed to allow for comparisons of the data between coordinated care organizations and must include the information required by subsection (5) of this section.

"(5) No 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 for 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; and

"(b) Each coordinated care organization's related party arrangements.

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

"SECTION 3. 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 2 of this 2016 Act on and after January 1, 2017.

"SECTION 4. (1) The Oregon Health Authority shall maintain a log of all of the 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 a single, easily accessible location, all written communications concerning coordinated care organizations that are exchanged 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 au-

thority sends or receives the communication. This subsection does not apply to communications that are exempt from disclosure under ORS 192.410 to 192.505.

"SECTION 5. Upon the expiration of the five-year term of a contract between the Oregon Health Authority and a coordinated care organization, as defined in ORS 414.025, the authority shall offer to contract with the coordinated care organization for another five-year term unless the coordinated care organization:

"(1) Substantially failed to carry out the terms of the contract;

"(2) Substantially failed to comply with federal law; or

"(3) Failed to make meaningful progress toward meeting the outcome and quality measures adopted by the authority under ORS 414.638.

"SECTION 6. 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) May not contain terms that are inconsistent with state or federal law;

"(b) Must incorporate the provisions of this section and ORS 414.067 and 414.625 and section 2 of this 2016 Act;

"[*(a)*] **(c)** Shall be for a term of five years;

"[*(b)*] **(d)** 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 or is otherwise in breach of the contract.*]

"[*(2) This section does not prohibit the authority from allowing 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 prior to the termination of the contract.*]

"(e) May be terminated if a coordinated care organization fails to meet outcome and quality measures 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) The authority shall provide a coordinated care organization with a written notice and a reasonable amount of time in which to cure any failure to meet outcome and quality measures, or criteria adopted by the authority under ORS 414.625, prior to the termination of the contract or the authority's refusal to renew or to enter into a new contract with the coordinated care organization.

"(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 for the coordinated care organization during the following 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) If a coordinated care organization, prior to agreeing to a contract term or proposed amendment to a contract with the authority, gives notice to the authority that the term or amendment conflicts with the provisions of this section or ORS 414.067 or 414.625 or section 2 of this 2016 Act, the coordinated care organization may file an action in circuit court to dispute the term or amendment. If the court finds that the term or amendment conflicts with the provisions of this section or ORS 414.067 or 414.625 or section 2 of this 2016 Act, the term or amendment shall be null and void retroactive to the date the coordinated care organization agreed to the term or amendment.

"(b) No later than 60 days after a coordinated care organization receives notice from the authority that the authority intends to amend a contract to reduce the coordinated care organization's global budget, the coordinated care organization may file an action in circuit court to dispute the proposed reduction based on the requirements of this section and section 2 of this 2016 Act.

"(c) An action described in this subsection may be filed in the Circuit Court for Marion County or the circuit court for the county in which the coordinated care organization has its principal place of business.

"(d) The authority may not terminate, refuse to renew or refuse to enter into a new contract with a coordinated care organization based upon the coordinated care organization's pursuit of its remedies under this subsection.

"SECTION 7. 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**

"(G) A person who requests exemption from mandatory enrollment in a coordinated care organization because the person's health care provider is not credentialed by a coordinated care organization. A

person described in this subparagraph shall remain exempt from mandatory enrollment in a coordinated care organization for no less than 60 days following the termination of the health care provider's services to the person.

"(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, 'American Indian and Alaskan Native beneficiary' means:

"(a) A member of a federally recognized Indian tribe;

"(b) An individual who resides in an urban center and:

"(A) 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) Is an Eskimo or Aleut or other Alaskan Native; or

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

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

"(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.

"SECTION 8. 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 45 days, or 90 days if the determination is based upon an applicant's disability, 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 9. (1) Section 2 of this 2016 Act and the amendments to ORS 411.404, 414.631 and 414.652 by sections 6 to 8 of this 2016 Act become operative January 1, 2017.

"(2) Section 4 of this 2016 Act becomes operative 18 months after the effective date of this 2016 Act.

"SECTION 10. Section 5 of this 2016 Act is repealed on January 2, 2026.

"SECTION 11. 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.".
