A-Engrossed
House Bill 2979

Ordered by the House April 20
Including House Amendments dated April 20

Sponsored by 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.

Eliminates certain categories of medical assistance recipients from exemption from enrollment in coordinated care organization. Requires Oregon Health Authority to enroll individuals in coordinated care organization no later than [*15*] **30** days after eligibility determination [*or*] **and immediately following** disenrollment from another coordinated care organization. **Requires authority to enroll individuals who are served by prepaid managed care health services organization because coordinated care organization does not serve area where individual resides, no later than 15 days after eligibility determination.**

A BILL FOR AN ACT

Relating to enrollment in coordinated care organizations; amending ORS 414.631, 414.635 and 414.654.

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

SECTION 1. 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) The Oregon Health Authority shall enroll an individual in a coordinated care organization no later than 30 days after the date that the authority determines that the individual is eligible for medical assistance. If an eligible individual who resides in an area served by two or more coordinated care organizations disenrolls from a coordinated care organization, the authority shall immediately enroll the individual in the coordinated care organization that the individual selects.

[*(2)*] **(3)** Subsections (1)**, (2)** and [*(4)*] **(5)** of this section do not apply to:

(a) [*A person*] **An individual** who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) [*A person*] **An individual** 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) An individual who is exempt by federal law from enrollment in a managed care organization; and

[*(d)*] **(e)** [*A person*] **The following individuals** whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of [*subsection (1)*] **subsections (1) and (2)** of

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.

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)** [*A person*] **An individual** under 18 years of age who is medically fragile and who has special health care needs; **and**

[*(E)*] **(B)** [*A person*] **An individual** receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1)[*; and*]

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

[*(3)*] **(4)** [*Subsection (1) of this section does*] **Subsections (1) and (2) of this section do** 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)*] **(5)** 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*] **the authority shall enroll an individual** with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization **no later than 15 days after the date that the individual is determined eligible for medical assistance**.

[*(5)*] **(6)** 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*] **An individual** 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 2. ORS 414.635 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 **immediately** 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)(a) The authority shall adopt by rule a process for resolving disputes involving:

(A) A health care entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section.

(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

(b) The processes adopted under this subsection 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.

SECTION 3. ORS 414.654 is amended to read:

414.654. (1)(a) The Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.025, that are in compliance with contractual obligations owed to the state or local government on July 27, 2015, and that serve:

(A) A geographic area of the state that a coordinated care organization has not been certified

to serve; or

(B) Individuals described in ORS 414.631 [*(2),*] (3)**,** [*and*] (4) **and (5)**.

(b) Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(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 ORS 414.153, 414.625, 414.635, 414.638, 414.651, 414.655, 414.679, 414.712, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743B.470.

(3) To facilitate the full adoption of health information technology by coordinated care organizations, patient centered primary care homes and behavioral health homes, the authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology.
