

Requested by Representative KOTEK

**PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 2122**

1 On page 1 of the printed A-engrossed bill, line 3, delete “and 414.627” and
2 insert “, 414.627 and 414.653”.

3 In line 9, after “is” delete the rest of the line and insert “:

4 “(a) Recognized as tax exempt under section 501(c)(3) of the Internal
5 Revenue Code of 1986; or

6 “(b) A public benefit corporation as defined in ORS 65.001.”.

7 On page 2, delete line 16 and insert:

8 “(C) Expend a portion of the annual net income or reserves of the coor-
9 dinated care”.

10 In line 19, after “plan” insert “and transformation plan and the terms and
11 conditions of the Medicaid demonstration project under section 1115 of the
12 Social Security Act (42 U.S.C. 1315)”.

13 On page 4, after line 16, insert:

14 **“SECTION 5. In the adoption of rules to implement the amend-
15 ments to ORS 414.625 (1)(b)(C) by section 4 of this 2017 Act, the Oregon
16 Health Authority shall:**

17 **“(1) Convene a rules advisory committee under ORS 183.333 that
18 includes one representative from each of the coordinated care organ-
19 izations and other stakeholders;**

20 **“(2) Take into consideration:**

21 **“(a) The variability of coordinated care organizations’ operating**

1 **budgets;**

2 **“(b) The obligations and investments of coordinated care organiza-**
3 **tions;**

4 **“(c) The variability in risk-sharing arrangements between coordi-**
5 **nated care organizations; and**

6 **“(d) The needed investments in infrastructure improvements that**
7 **coordinated care organizations must make to ensure the long term**
8 **viability of the coordinated care organizations’ ability to provide ser-**
9 **vices; and**

10 **“(3) Consult with the Department of Consumer and Business Ser-**
11 **vices with respect to financial requirements imposed on a coordinated**
12 **care organization that is regulated by the department.”.**

13 In line 17, delete “5” and insert “6”.

14 On page 5, line 21, delete “6” and insert “7”.

15 On page 8, after line 39, insert:

16 **“(25) ‘Transformation plan’ means the terms in a contract between the**
17 **authority and a coordinated care organization that specify the benchmarks**
18 **that the coordinated care organization must meet in order to comply with**
19 **the provisions of ORS 414.625.**

20 **“SECTION 8. ORS 414.653 is amended to read:**

21 **“414.653. (1) The Oregon Health Authority shall encourage coordinated**
22 **care organizations to use alternative payment methodologies that:**

23 **“(a) Reimburse providers on the basis of health outcomes and quality**
24 **measures instead of the volume of care;**

25 **“(b) Hold organizations and providers responsible for the efficient deliv-**
26 **ery of quality care;**

27 **“(c) Reward good performance;**

28 **“(d) Limit increases in medical costs; and**

29 **“(e) Use payment structures that create incentives to:**

30 **“(A) Promote prevention;**

1 “(B) Provide person centered care; and

2 “(C) Reward comprehensive care coordination using delivery models such
3 as patient centered primary care homes and behavioral health homes.

4 “(2) The authority shall [*encourage*] **work with each** coordinated care
5 [*organizations to utilize*] **organization to develop individual plans to**
6 **move each coordinated care organization toward greater utilization of**
7 alternative payment methodologies [*that move from a predominantly fee-for-*
8 *service system to payment methods*] that base reimbursement on the quality
9 rather than the quantity of services provided. **Each plan must:**

10 “(a) **Describe how the authority will work with coordinated care**
11 **organizations and contracted providers to ensure that, by December**
12 **31, 2023, coordinated care organizations meet benchmarks established**
13 **by the authority in the use of alternative payment methodologies to**
14 **reimburse providers;**

15 “(b) **Provide a broad definition of alternative payment methodol-**
16 **ogies that aligns with the payment models developed by the Center for**
17 **Medicaid and Medicare Innovation; and**

18 “(c) **Allow a coordinated care organization to phase in the use of**
19 **alternative payment methodologies over the term of the coordinated**
20 **care organization’s contract with the authority.**

21 “(3) The authority shall assist and support coordinated care organizations
22 in identifying cost-cutting measures.

23 “(4) If a service provided in a health care facility is not covered by
24 Medicare because the service is related to a health care acquired condition,
25 the cost of the service may not be:

26 “(a) Charged by a health care facility or any health services provider
27 employed by or with privileges at the facility, to a coordinated care organ-
28 ization, a patient or a third-party payer; or

29 “(b) Reimbursed by a coordinated care organization.

30 “(5)(a) Notwithstanding subsections (1) and (2) of this section, until July

1 1, 2014, a coordinated care organization that contracts with a Type A or Type
2 B hospital or a rural critical access hospital, as described in ORS 442.470,
3 shall reimburse the hospital fully for the cost of covered services based on
4 the cost-to-charge ratio used for each hospital in setting the global payments
5 to the coordinated care organization for the contract period.

6 “(b) The authority shall base the global payments to coordinated care
7 organizations that contract with rural hospitals described in this section on
8 the most recent audited Medicare cost report for Oregon hospitals adjusted
9 to reflect the Medicaid mix of services.

10 “(c) The authority shall identify any rural hospital that would not be
11 expected to remain financially viable if paid in a manner other than as pre-
12 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation
13 by an actuary retained by the authority. On and after July 1, 2014, the au-
14 thority may, on a case-by-case basis, require a coordinated care organization
15 to continue to reimburse a rural hospital determined to be at financial risk,
16 in the manner prescribed in paragraphs (a) and (b) of this subsection.

17 “(d) This subsection does not prohibit a coordinated care organization and
18 a hospital from mutually agreeing to reimbursement other than the re-
19 imbursement specified in paragraph (a) of this subsection.

20 “(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection
21 are not entitled to any additional reimbursement for services provided.

22 “(6) Notwithstanding subsections (1) and (2) of this section, coordinated
23 care organizations must comply with federal requirements for payments to
24 providers of Indian health services, including but not limited to the re-
25 quirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

26 “**SECTION 9.** ORS 414.653, as amended by section 8 of this 2017 Act, is
27 amended to read:

28 “414.653. (1) The Oregon Health Authority shall encourage coordinated
29 care organizations to use alternative payment methodologies that:

30 “(a) Reimburse providers on the basis of health outcomes and quality

1 measures instead of the volume of care;

2 “(b) Hold organizations and providers responsible for the efficient deliv-
3 ery of quality care;

4 “(c) Reward good performance;

5 “(d) Limit increases in medical costs; and

6 “(e) Use payment structures that create incentives to:

7 “(A) Promote prevention;

8 “(B) Provide person centered care; and

9 “(C) Reward comprehensive care coordination using delivery models such
10 as patient centered primary care homes and behavioral health homes.

11 “[~~(2)~~ *The authority shall work with each coordinated care organization to*
12 *develop individual plans to move each coordinated care organization toward*
13 *greater utilization of alternative payment methodologies that base reimburse-*
14 *ment on the quality rather than the quantity of services provided. Each plan*
15 *must:]*

16 “[~~(a)~~ *Describe how the authority will work with coordinated care organ-*
17 *izations and contracted providers to ensure that, by December 31, 2023, coor-*
18 *dated care organizations meet benchmarks established by the authority in the*
19 *use of alternative payment methodologies to reimburse providers;]*

20 “[~~(b)~~ *Provide a broad definition of alternative payment methodologies that*
21 *aligns with the payment models developed by the Center for Medicaid and*
22 *Medicare Innovation; and]*

23 “[~~(c)~~ *Allow a coordinated care organization to phase in the use of alterna-*
24 *tive payment methodologies over the term of the coordinated care organization’s*
25 *contract with the authority.]*

26 “[~~(3)~~ **(2)** The authority shall assist and support coordinated care organ-
27 izations in identifying cost-cutting measures.

28 “[~~(4)~~ **(3)** If a service provided in a health care facility is not covered by
29 Medicare because the service is related to a health care acquired condition,
30 the cost of the service may not be:

1 “(a) Charged by a health care facility or any health services provider
2 employed by or with privileges at the facility, to a coordinated care organ-
3 ization, a patient or a third-party payer; or

4 “(b) Reimbursed by a coordinated care organization.

5 “[5(a)] **(4)(a)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)**
6 of this section, until July 1, 2014, a coordinated care organization that con-
7 tracts with a Type A or Type B hospital or a rural critical access hospital,
8 as described in ORS 442.470, shall reimburse the hospital fully for the cost
9 of covered services based on the cost-to-charge ratio used for each hospital
10 in setting the global payments to the coordinated care organization for the
11 contract period.

12 “(b) The authority shall base the global payments to coordinated care
13 organizations that contract with rural hospitals described in this section on
14 the most recent audited Medicare cost report for Oregon hospitals adjusted
15 to reflect the Medicaid mix of services.

16 “(c) The authority shall identify any rural hospital that would not be
17 expected to remain financially viable if paid in a manner other than as pre-
18 scribed in paragraphs (a) and (b) of this subsection based upon an evaluation
19 by an actuary retained by the authority. On and after July 1, 2014, the au-
20 thority may, on a case-by-case basis, require a coordinated care organization
21 to continue to reimburse a rural hospital determined to be at financial risk,
22 in the manner prescribed in paragraphs (a) and (b) of this subsection.

23 “(d) This subsection does not prohibit a coordinated care organization and
24 a hospital from mutually agreeing to reimbursement other than the re-
25 imbursement specified in paragraph (a) of this subsection.

26 “(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection
27 are not entitled to any additional reimbursement for services provided.

28 “[6] **(5)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** of this
29 section, coordinated care organizations must comply with federal require-
30 ments for payments to providers of Indian health services, including but not

1 limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C.
2 1396u-2(a)(2)(C).”.

3 In line 40, delete “7” and insert “10”.

4 In line 41, delete “to 6” and insert “, 6 and 7”.

5 On page 9, after line 1, insert:

6 **“SECTION 11. The amendments to ORS 414.653 by section 9 of this
7 2017 Act become operative on January 1, 2024.**

8 **“SECTION 12. Section 5 of this 2017 Act is repealed on December
9 31, 2019.”.**

10 In line 2, delete “8” and insert “13”.

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