HB 2122-A15
(LC 287)
5/4/17 (LHF/ps)

Requested by Representative KOTEK

PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 2122

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

In line 9, after "is" delete the rest of the line and insert ":

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

"(b) A public benefit corporation as defined in ORS 65.001.".

On page 2, delete line 16 and insert:

"(C) Expend a portion of the annual net income or reserves of the coordinated care".

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

On page 4, after line 16, insert:

"SECTION 5. In the adoption of rules to implement the amendments to ORS 414.625 (1)(b)(C) by section 4 of this 2017 Act, the Oregon Health Authority shall:

"(1) Convene a rules advisory committee under ORS 183.333 that includes one representative from each of the coordinated care organizations and other stakeholders;

"(2) Take into consideration:

"(a) The variability of coordinated care organizations' operating

budgets;

"(b) The obligations and investments of coordinated care organizations;

"(c) The variability in risk-sharing arrangements between coordinated care organizations; and

"(d) The needed investments in infrastructure improvements that coordinated care organizations must make to ensure the long term viability of the coordinated care organizations' ability to provide services; and

"(3) Consult with the Department of Consumer and Business Services with respect to financial requirements imposed on a coordinated care organization that is regulated by the department.".

In line 17, delete "5" and insert "6".

On page 5, line 21, delete "6" and insert "7".

On page 8, after line 39, insert:

"(25) 'Transformation plan' means the terms in a contract between the authority and a coordinated care organization that specify the benchmarks that the coordinated care organization must meet in order to comply with the provisions of ORS 414.625.

"**SECTION 8.** 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 and behavioral health homes.

"(2) The authority shall [*encourage*] **work with each** coordinated care [*organizations to utilize*] **organization to develop individual plans to move each coordinated care organization toward greater utilization of** 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. **Each plan must:**

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

"(b) Provide a broad definition of alternative payment methodologies that aligns with the payment models developed by the Center for Medicaid and Medicare Innovation; and

"(c) Allow a coordinated care organization to phase in the use of alternative payment methodologies over the term of the coordinated care organization's contract with the authority.

"(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).

"SECTION 9. ORS 414.653, as amended by section 8 of this 2017 Act, 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 and behavioral health homes.

"[*(2) The authority shall work with each coordinated care organization to develop individual plans to move each coordinated care organization toward greater utilization of alternative payment methodologies that base reimbursement on the quality rather than the quantity of services provided. Each plan must:*]

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

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

"[*(c) Allow a coordinated care organization to phase in the use of alternative payment methodologies over the term of the coordinated care organization's contract with the authority.*]

"[*(3)*] **(2)** The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

"[*(4)*] **(3)** 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)*] **(4)(a)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** 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)*] **(5)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** 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).".

In line 40, delete "7" and insert "10".

In line 41, delete "to 6" and insert ", 6 and 7".

On page 9, after line 1, insert:

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

"SECTION 12. Section 5 of this 2017 Act is repealed on December 31, 2019.".

In line 2, delete "8" and insert "13".
