SB 1041-A6
(LC 2605)
5/16/19 (LHF/ps)

Requested by Representative KENY-GUYER

PROPOSED AMENDMENTS TO
A-ENGROSSED SENATE BILL 1041

On page 3 of the printed A-engrossed bill, line 26, delete "(2)(g)" and insert "(2)(h)".

On page 12, line 2, delete "(2)(i)" and insert "(2)(j)".

On page 28, after line 43, insert:

"SECTION 59. Sections 60 to 64 of this 2019 Act are added to and made a part of ORS chapter 413.

"SECTION 60. As used in sections 60 to 64 of this 2019 Act:

"(1) 'Category of service' means the categories of medical expenditures that the Oregon Health Authority uses in setting global budgets such as:

"(a) Inpatient and outpatient hospital services;

"(b) Primary care and specialists;

"(c) Prescription drugs; and

"(d) Mental health services.

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

"(3) 'Per capita costs' means a coordinated care organization's expected average costs per member during a specified period of time.

"(4) 'Related party' means an entity that:

"(a) Enters into any type of arrangement with or receives services from a coordinated care organization directly or through one or more

unrelated parties; and

"(b) Is associated with the coordinated care organization by any form of common, privately held ownership, control or investment.

"(5) 'Risk accepting entity' means an entity that:

"(a) Enters into an arrangement or agreement with a coordinated care organization to provide health services to members of the coordinated care organization;

"(b) Assumes the financial risk of providing health services to medical assistance recipients; and

"(c) Is compensated on a prepaid capitated basis for providing health services to members of a coordinated care organization.

"(6) 'Risk adjusted rate of growth' means the percentage change in a coordinated care organization's health care expenditures from one year to the next year, taking into account the variability in the relative health status of the members of the coordinated care organization from one year to the next year.

"(7) 'Risk score' means a factor intended to predict how a coordinated care organization's incurred costs for a member will differ from the statewide average based upon:

"(a) Age;

"(b) Sex;

"(c) Eligibility category;

"(d) Health status; and

"(e) Geographic region.

"(8) 'Total compensation' includes salary and benefits paid by a coordinated care organization and compensation paid by shareholders, subsidiaries, parent companies, related parties and risk accepting entities of the coordinated care organization.

"SECTION 61. (1) It is the intent of the Legislative Assembly that the expenditures of the Oregon Health Authority in administering the

medical assistance program and the manner in which the authority establishes global budgets for coordinated care organizations be fully transparent and available to the public.

"(2) The authority shall make available to the public the following information in an easily accessible manner:

"(a) All documentation submitted to the Centers for Medicare and Medicaid Services by the authority in seeking federal approval of global budgets for coordinated care organizations, including but not limited to:

"(A) Any documents certifying that the global budgets are actuarially sound as required by 42 C.F.R. 438.4; and

"(B) Any correspondence regarding a coordinated care organization contract or modifications to a global budget paid to a coordinated care organization.

"(b) All documents, financial data and health care utilization data considered by the authority in calculating global budgets for each coordinated care organization for each year beginning with 2013, 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 the eligibility categories of the members.

"(c) For calendar years beginning on January 1, 2013:

"(A) The total annual expenditures by the authority for programs administered by the authority that receive funds under Title XIX or XXI of the Social Security Act and expenditures on administration and on health services in each program.

"(B) The total annual expenditures by the Department of Human Services for programs administered by the department that receive funds under Title XIX or XXI of the Social Security Act and expenditures on administration and on health services in each program.

"(C) The total annual expenditures by the authority and the department in programs administered by each agency using funds from Title XIX or XXI of the Social Security Act on the following categories of health services, if applicable:

"(i) Public health nurse home visits to postpartum mothers;

"(ii) Adult residential mental health services;

"(iii) Cost sharing for Medicare skilled nursing facility care;

"(iv) Transitional mental health residential care for young adults;

"(v) Targeted case management;

"(vi) Wrap around services provided to patients served by federally qualified health centers or rural health centers;

"(vii) Mental health services reimbursed on a fee-for-service basis;

"(viii) Long term care services;

"(ix) School-based health services;

"(x) Behavioral rehabilitative services;

"(xi) In-home personal care services;

"(xii) Home and community-based services provided pursuant to a state plan amendment under section 1915(i) of the Social Security Act;

"(xiii) Hospital services provided to medical assistance recipients who were determined eligible for medical assistance by a hospital under criteria for presumptive determinations of eligibility;

"(xiv) Health insurer fees; and

"(xv) Hospital payments described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003.

"SECTION 62. (1) It is the intent of the Legislative Assembly that the expenditures of a coordinated care organization serving medical assistance recipients be fully transparent and available to the public.

"(2) The Oregon Health Authority shall make readily available to the public on an easily accessible website, and shall annually report to the Legislative Assembly, the following information for the preced-

ing calendar year regarding each coordinated care organization contracting with the authority:

"(a) The three highest paid positions, total compensation paid to each position and to the positions combined and the name of the individuals who hold or have held the positions.

"(b) All financial distributions by the coordinated care organization to shareholders, equity members, parent companies or any related parties.

"(c) A description and the amount of each type of financial transaction between the coordinated care organization and the coordinated care organization's related parties and risk accepting entities.

"(d) The net assets of the coordinated care organization's risk accepting entities at the end of each calendar year.

"(e) The annual audited financial statements of the coordinated care organization.

"(f) Copies of federal tax returns filed by the coordinated care organization.

"(g) The annual risk adjusted rate of growth for the coordinated care organization.

"(h) Every report and all data submitted by the coordinated care organization to the authority as required in the coordinated care organization's contract with the authority except reports or data that disclose information about individual members or individual providers.

"(3) The information described in subsection (2) of this section must be provided for each calendar year beginning with 2013.

"(4)(a) Except as provided in paragraph (b) of this subsection, the authority shall post the information described in subsection (2) of this section no later than August 1 of the year following the year that the information is reported.

"(b) Tax information described in subsection (2)(f) of this section

must be posted to the website no later than 30 days after receipt by the authority.

"SECTION 63. (1) The Oregon Health Authority shall adopt by rule uniform data reporting requirements for coordinated care organizations. The authority shall provide to each coordinated care organization the risk scores for the members of the coordinated care organization and the data supporting the calculation of the global budget in sufficient detail to allow the coordinated care organization to reconcile the data provided by the authority with the coordinated care organization's own data.

"(2) The data provided by the authority under subsection (1) of this section shall include, but is not limited to, the information described in section 61 of this 2019 Act. The authority must provide to coordinated care organizations the risk scores and data, and the per capita cost report described in section 64 of this 2019 Act, no later than 90 days prior to the effective date of a global budget established by the authority that is based on the risk scores, the data and the per capita costs.

"(3) The authority shall use accurate and uniform standards for measuring and reporting coordinated care organization medical loss ratios, administrative costs and earnings to the public, the Legislative Assembly and the Centers for Medicare and Medicaid Services.

"(4) The authority shall provide to each coordinated care organization, no later than October 1 of each year, the quality measures and the specifications for the quality measures that the coordinated care organization must satisfy to qualify for quality incentive payments in the following year.

"SECTION 64. (1) Beginning January 1, 2020, the Oregon Health Authority shall create and publish annually a per capita cost report of the costs incurred and reported to the authority by coordinated care

organizations and used by the authority to calculate global budgets. The costs reported for the period of January 1, 2018, to December 31, 2018, shall serve as the primary data source for the 2020 report, and the authority shall update the data each year.

"(2) The per capita cost report must include:

"(a) A description of the data sources used in producing the exhibits described in paragraph (e) of this subsection;

"(b) A description of the methods and assumptions that the authority used in producing the exhibits described in paragraph (e) of this subsection;

"(c) A description of each category of service;

"(d) The distribution of coordinated care organization members by eligibility category; and

"(e) The following exhibits, presenting information as a weighted statewide average by eligibility category for all coordinated care organizations combined:

"(A) Descriptions of each eligibility category;

"(B) An explanation of how a unit of utilization is measured for each category of service;

"(C) The unadjusted utilization rates for each category of service per 1,000 members;

"(D) The unadjusted average billed charge for each unit of service;

"(E) The unadjusted average billed charges per member per month;

"(F) The unadjusted average total payments per member per month;

"(G) A detailed description of any adjustments made for:

"(i) Services that are not reported by coordinated care organizations in their cost or encounter data;

"(ii) Services that are not appropriate for including in the per capita costs;

"(iii) Changes in policies adopted by the authority made during the data reporting period; and

"(iv) Services that are reported in the data but are not reimbursed by the medical assistance program;

"(H) Annual trend factors that the authority used to update the data;

"(I) Adjusted utilization rates for each category of service per 1,000 members;

"(J) The adjusted projected cost of service per unit;

"(K) Average monthly incurred costs per member;

"(L) The percentage of members by eligibility category utilizing each of the following categories of service:

"(i) Physical health services;

"(ii) Dental health services; and

"(iii) Behavioral health services; and

"(M) Average incurred costs by eligibility category, including administrative costs, for:

"(i) Physical health services;

"(ii) Dental health services;

"(iii) Behavioral health services; and

"(iv) All health services.

"SECTION 65. (1) The Oregon Health Authority shall report all information described in sections 60 to 64 of this 2019 Act, that is made available to the public, in a manner that is uniform and sufficiently detailed to ensure accurate comparisons of the data between coordinated care organizations.

"(2) Information and data that must be made public under sections 60 to 64 of this 2019 Act are not trade secrets under ORS 192.345 except for data that identifies individual members or the contract terms or reimbursement rates of individual providers.

"**SECTION 66.** Section 61 of this 2019 Act is amended to read:

"**Sec. 61.** (1) It is the intent of the Legislative Assembly that the expenditures of the Oregon Health Authority in administering the medical assistance program and the manner in which the authority establishes global budgets for coordinated care organizations be fully transparent and available to the public.

"(2) The authority shall make available to the public the following information in an easily accessible manner:

"(a) All documentation submitted to the Centers for Medicare and Medicaid Services by the authority in seeking federal approval of global budgets for coordinated care organizations, including but not limited to:

"(A) Any documents certifying that the global budgets are actuarially sound as required by 42 C.F.R. 438.4; and

"(B) Any correspondence regarding a coordinated care organization contract or modifications to a global budget paid to a coordinated care organization.

"(b) All documents, financial data and health care utilization data considered by the authority in calculating global budgets for each coordinated care organization for each year beginning with 2013, 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 the eligibility categories of the members.

"(c) For calendar years beginning on January 1, 2013:

"(A) The total annual expenditures by the authority for programs administered by the authority that receive funds under Title XIX or XXI of the Social Security Act and expenditures on administration and on health services in each program.

"(B) The total annual expenditures by the Department of Human Services for programs administered by the department that receive funds under Title XIX or XXI of the Social Security Act and expenditures on administration

and on health services in each program.

"(C) The total annual expenditures by the authority and the department in programs administered by each agency using funds from Title XIX or XXI of the Social Security Act on the following categories of health services, if applicable:

"(i) Public health nurse home visits to postpartum mothers;

"(ii) Adult residential mental health services;

"(iii) Cost sharing for Medicare skilled nursing facility care;

"(iv) Transitional mental health residential care for young adults;

"(v) Targeted case management;

"(vi) Wrap around services provided to patients served by federally qualified health centers or rural health centers;

"(vii) Mental health services reimbursed on a fee-for-service basis;

"(viii) Long term care services;

"(ix) School-based health services;

"(x) Behavioral rehabilitative services;

"(xi) In-home personal care services;

"(xii) Home and community-based services provided pursuant to a state plan amendment under section 1915(i) of the Social Security Act;

"(xiii) Hospital services provided to medical assistance recipients who were determined eligible for medical assistance by a hospital under criteria for presumptive determinations of eligibility; **and**

"(xiv) Health insurer fees[*; and*]**.**

"[*(xv) Hospital payments described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003.*]

"SECTION 67. The amendments to section 61 of this 2019 Act by section 66 of this 2019 Act become operative on January 2, 2031.".
