

House Bill 4069

Sponsored by Representative DEXTER (Presession filed.)

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 **as introduced**. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act creates a new pilot program to test new ways to pay for health care. The Act sets out the requirements for the program and specifies the steps that the Oregon Health Authority must take to roll out the program. (Flesch Readability Score: 70.7).

Establishes the Aligning for Health Pilot Program, administered by the Oregon Health Authority, to test alternative methods for paying for health care. Prescribes the requirements for the pilot program and the steps in the implementation.

Sunset January 2, 2035.

A BILL FOR AN ACT

1
2 Relating to paying for health care.

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

4 **SECTION 1. (1) The Aligning for Health Pilot Program is established to be administered**
5 **by the Oregon Health Authority. The goals of the program are to:**

6 (a) **Establish more predictable, aligned payment models, metrics and other expectations**
7 **for providers regardless of the payer;**

8 (b) **Increase the number of providers receiving population-based payments that are tied**
9 **to health outcomes;**

10 (c) **Reward health systems for keeping people healthy and containing costs;**

11 (d) **Give health systems and providers flexibility to be more innovative in how they de-**
12 **liver care and address the complex drivers of health;**

13 (e) **Provide more equitable and meaningful access to quality health services and better**
14 **health outcomes; and**

15 (f) **Ensure that the program is consistent with the legislative intent expressed in ORS**
16 **414.018 and the system design described in ORS 414.570 (1).**

17 (2) **In the first phase of implementing the Aligning for Health Pilot Program, the au-**
18 **thority shall plan for the launch of the program by:**

19 (a) **Hiring program staff and working collaboratively with the Public Employees' Benefit**
20 **Board and the Oregon Educators Benefit Board in creating external contracts;**

21 (b) **Conducting legal, actuarial and regulatory analyses;**

22 (c) **Engaging with payers, purchasers, community-based organizations and providers to**
23 **gauge interest in participation in the program; and**

24 (d) **Identifying one or more potential geographic regions where the program may begin.**

25 (3) **In the second phase of implementing the program, the authority shall:**

26 (a) **Finalize the risk mitigation strategies to be used in the program, including by estab-**
27 **lishing a health equity fund. The program must phase in the implementation of downside risk**
28 **for safety net providers and smaller organizations serving vulnerable populations consistent**

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.

1 with the principles of the Value-Based Payment Compact. Other risk mitigation strategies
 2 may include, but are not limited to, one or more of the following:

- 3 (A) Use of the Oregon Reinsurance Program or stop-loss;
- 4 (B) Risk corridors; and
- 5 (C) A risk stabilization fund.

6 (b) Engage providers in target geographic regions by providing technical support funded
 7 by the authority for financial and actuarial simulation of the potential financial risk to pro-
 8 viders if they choose to participate in the Aligning for Health Pilot Program, prioritizing
 9 providers with value-based payment experience.

- 10 (c) Open a request for proposal developed in partnership with purchasers that includes:
 11 (A) Standardized quality and outcome performance measures;
 12 (B) Features to address and reduce health inequities in the geographic regions; and
 13 (C) A requirement for a meaningful demonstration of interested parties' intents to com-
 14 mit to participate at the community and system levels.

15 (d) Solicit employer groups and other payers, especially those that are signatories to the
 16 Value-Based Payment Compact.

17 (4) In the third phase of implementing the program, the authority:

18 (a) Shall award individual three-year contracts to include Public Employees' Benefit
 19 Board members, Oregon Educators Benefit Board members and one or more commercial
 20 payers;

21 (b) Shall launch the program; and

22 (c) May add additional regions and participants following the launch of the program.

23 (5)(a) Payers participating in the program shall:

24 (A) Sign on to the Value-Based Payment Compact;

25 (B) Stay within the global budget established by the authority and share risk with pro-
 26 viders using mutually negotiated value-based payment agreements;

27 (C) Agree to a fixed rate of growth in the global budget; and

28 (D) Partner with community-based organizations operating in the pilot regions.

29 (b) Payers participating in the program may be required to invest a set percentage of
 30 total revenue toward social determinants of health and annually report how the moneys were
 31 spent.

32 (c) Payers participating in the program are exempt from the requirements of ORS 415.501
 33 while they are participating.

34 (6) Providers participating in the program:

35 (a) Generally assume accountability for a defined group of patients;

36 (b) Bear financial risk for spending targets;

37 (c) Are eligible for bonuses for quality;

38 (d) Must agree to participate in a value-based payment agreement consistent with the
 39 goals of the Value-Based Payment Compact; and

40 (e) Are subject to the health outcome and quality measures and benchmarks established
 41 by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in
 42 accordance with ORS 413.017 (4) and 413.022, and the Behavioral Health Committee in ac-
 43 cordance with ORS 413.017 (5).

44 (7) Purchasers participating in the program select their own benefit packages and may
 45 adjust the benefit packages as desired. Benefit packages must include medical, pharmacy

1 and behavioral health benefits and may include dental or vision benefits.

2 (8) All participating payers and purchasers must agree to include in the program all of
3 their enrollees, members or beneficiaries who reside in the pilot region.

4 (9) All payers, purchasers and providers, except nonemployer individual purchasers of
5 insurance, must agree to:

6 (a) Adhere to the health care cost growth targets established under ORS 442.386; and

7 (b) Not reduce access to care or reduce benefits to achieve cost savings.

8 (10) The authority shall:

9 (a) Be responsible for procurement and contracting processes.

10 (b) In collaboration with the Department of Consumer and Business Services, set global
11 budgets based on per member per month rates and on quality measures that are risk-
12 adjusted specifically for each payer's benefit packages, enrollee health status and other rel-
13 evant adjustments. In areas with substantial and disproportionate numbers of high-risk or
14 vulnerable patients, the authority shall adjust per member per month rates to account for
15 the differing levels of need.

16 (c) Establish a process for payers to appeal rates.

17 (d) Establish a model process that payers may use to set provider rates and to risk-adjust
18 provider rates to avoid penalizing providers that care for higher need patient populations.

19 (e) Ensure that costs are not excessively shifted to enrollees.

20 (f) Subject to subsection (12) of this section, provide regulatory relief for payers and
21 providers and give payers and providers sufficient flexibility from state regulations to provide
22 incentives for innovation.

23 (g) Offset administrative burdens, especially on providers, with the development of and
24 state investment in a centralized infrastructure to allow for complete and transparent re-
25 porting of data.

26 (h) Apply equity-related performance measures and tie earning incentives to the meas-
27 ures.

28 (i) Establish a monitoring system with requirements for participant reporting.

29 (j) Collect data that pilot program participants and the authority mutually agree upon for
30 cost and quality measures to ensure that participation in the program does not reduce access
31 to care or benefits for individuals residing in a pilot region.

32 (k) Construct a comparison group representing patients or providers that are not par-
33 ticipating in the program to determine the program's impact.

34 (L) During the early stages of the program, collect and share information on a regular
35 and timely basis with participants so that participants can make improvements during the
36 initial stages.

37 (11) To the extent practicable, the Public Employees' Benefit Board and the Oregon Ed-
38 ucators Benefit Board must be assured the ability, using risk mitigation strategies or other
39 means, to maintain their single risk pools, statewide rating approaches and 3.4 percent an-
40 nual cost growth targets.

41 (12) The authority may not provide regulatory relief under subsection (10)(f) of this sec-
42 tion that:

43 (a) Impacts workforce requirements such as patient to staff ratios and staffing commit-
44 tees; or

45 (b) Is likely to endanger the health or safety of patients or providers.

1 (13)(a) The authority shall convene a pilot region advisory group for each region partic-
 2 ipating in the pilot to make recommendations to the authority regarding the health equity
 3 fund described in subsection (3) of this section. The recommendations must include a formula
 4 or process for determining payers' contributions to the fund and criteria for distributions to
 5 the community from the fund.

6 (b) A majority of the membership of a pilot region advisory group must consist of indi-
 7 viduals representing:

- 8 (A) Communities of color;
- 9 (B) Tribal communities;
- 10 (C) Immigrants and refugees;
- 11 (D) Participating purchasers; and
- 12 (E) Rural, frontier or underserved areas.

13 (c) Membership on a pilot region advisory group must ensure to the greatest extent
 14 practicable proportional geographic representation across the entire region.

15 (d) Members of a pilot region advisory group described in paragraph (b)(A), (B) and (C)
 16 of this subsection must accurately represent the high social needs and substantial health
 17 inequities of the groups in the region that are represented.

18 (14) Any investments in the regional health equity fund described in subsection (3) of this
 19 section must align to the greatest extent practicable with other community investment
 20 strategies used by the pilot program participants.

21 (15) As used in this section:

22 (a) "Global budget" means a financial arrangement that establishes an annual, predeter-
 23 mined total cost of health care for a defined population, calculated based on the health of the
 24 population, defined provider reimbursement rates, covered benefits, geographic location and
 25 priorities for addressing social determinants of health. A global budget is not recalculated
 26 based on the prior year's actual spending but increases at a defined rate of growth.

27 (b) "Health equity fund" means a program in which multiple payers invest collectively in
 28 a fund that finances community-based interventions targeting social issues such as food in-
 29 security, housing instability, transportation and structural racism.

30 (c) "Payer" includes:

- 31 (A) Insurance carriers.
- 32 (B) Coordinated care organizations, as defined in ORS 414.025.
- 33 (C) Third party administrators.
- 34 (D) Individuals purchasing insurance on or off of the health insurance exchange.
- 35 (E) Government insurance programs including Medicaid and Medicare.

36 (d) "Purchaser" includes:

- 37 (A) Purchasers of commercial health insurance.
- 38 (B) Private employer groups.
- 39 (C) The Public Employees' Benefit Board.
- 40 (D) The Oregon Educators Benefit Board.

41 (e) "Risk-adjust" means to make a modification to a payment to account for the provision
 42 of care to populations with higher needs and the expected utilization of the populations.

43 (f) "Risk corridor" means an established floor for losses and a cap on gains to protect
 44 against inaccurate rate setting.

45 (g) "Risk stabilization fund" means a multiyear risk pool that allows provider gains above

1 a certain threshold to be placed in a reserve account to be retained for future periods when
2 the provider experiences unfavorable financial results.

3 (h) "Stop-loss" means a process for providing payments to payers or providers for
4 treatment costs that exceed a certain threshold.

5 (i) "Value-based payment" means a reimbursement methodology that makes
6 performance-based adjustments to a base payment to hold health care providers financially
7 accountable for improving quality and lowering health care costs.

8 **SECTION 2.** During the first five years of the Aligning for Health Pilot Program estab-
9 lished in section 1 of this 2024 Act, the fixed rate of growth in the global budgets under
10 section 1 (6)(a)(C) of this 2024 Act shall be:

11 (1) At the medical rate of inflation during the first 12-month period of the program.

12 (2) Decreased by 0.5 percent for each subsequent 12-month period of the program through
13 the fifth year of the program.

14 **SECTION 3.** (1) The Oregon Health Authority shall adopt rules for the timing of each
15 phase of implementing the Aligning for Health Pilot Program established in section 1 of this
16 2024 Act. The authority may align the timing of implementation with the timing of new
17 provider or network contract discussions.

18 (2) The authority shall conduct an interim assessment of the program following the
19 completion of the first phase of the program and make appropriate adjustments to the pro-
20 gram.

21 (3) Upon the close of the request for proposal period, the authority shall submit to the
22 committees or interim committees of the Legislative Assembly related to health a report of
23 the responses that the authority received to the request for proposal issued for the program.

24 (4) Following the implementation of the third phase of the program, the authority shall
25 complete a formal evaluation of the pilot program and report to the committees or interim
26 committees of the Legislative Assembly related to health, in the manner provided in ORS
27 192.245, the success of the program in achieving the goals described in section 1 of this 2024
28 Act and recommendations for continuing or expanding the pilot program in the future.

29 **SECTION 4.** Sections 1 to 3 of this 2024 Act are repealed on January 2, 2035.

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