B-Engrossed
House Bill 2216

Ordered by the House May 10
Including House Amendments dated March 14 and May 10

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor John A. Kitzhaber, M.D.)

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.

Extends sunset on collection of hospital assessment to September 30, 2015. Modifies payment methodology for reimbursement of specified hospitals by state medical assistance program. Authorizes quality improvement incentive payments to hospitals that meet standards adopted by Oregon Health Authority based on recommendations from hospital performance metrics advisory committee.

Establishes process for reducing excess long term care facility bed capacity statewide. Grants antitrust immunity to long term care facilities that participate in process. Modifies procedure for review of applications for certificates of need by long term care facilities.

Modifies long term care facility assessment and long term care facility reimbursement formula. Makes waivered long term care facilities, including long term care facilities operated by continuing care retirement communities, subject to long term care facility assessment. Extends long term care facility assessment to July 1, 2020.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to state medical assistance program funding; creating new provisions; amending ORS 414.746, 442.015 and 442.315 and sections 2, 3, 6, 7, 8, 9, 10, 12, 13, 18, 23, 24 and 31, chapter 736, Oregon Laws 2003; repealing ORS 414.746; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

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

SECTION 1. (1) As used in this section, "hospital" means a hospital that is subject to the assessment imposed under section 2, chapter 736, Oregon Laws 2003.

(2) In consultation with the President of the Senate and the Speaker of the House of Representatives, the Director of the Oregon Health Authority shall appoint a hospital performance metrics advisory committee consisting of nine members, including:

(a) Four members who represent hospitals;

(b) Three members who have expertise in measuring health outcomes; and

(c) Two members who represent coordinated care organizations.

(3) The hospital performance metrics advisory committee shall recommend three to five performance standards that are reasonably attainable by hospitals within the biennium beginning July 1, 2013, and that are consistent with state and national quality standards.

(4) The Oregon Health Authority shall adopt by rule the procedures for distributing to hospitals the moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, to ensure that such moneys are distributed as follows:

(a) The authority shall distribute 50 percent of the moneys based upon each hospital's

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.

compliance with data submission requirements.

(b) The authority shall distribute the remainder of the moneys based upon each hospital's achievement of the performance standards recommended by the hospital performance metrics advisory committee under subsection (3) of this section.

SECTION 2. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, and section 17, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) The assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (6) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(A) The adjustment to the capitation rate paid to Medicaid managed care organizations under section 15, chapter 867, Oregon Laws 2009;*]

[*(B)*] **(A)** 30 percent of payments made to **the** hospitals on a fee-for-service basis by the authority for inpatient hospital services; [*and*]

[*(C)*] **(B)** 41 percent of payments made to **the** hospitals on a fee-for-service basis by the authority for outpatient hospital services[.]**; and**

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed for the biennium beginning July 1, [*2009*] **2013**, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for that biennium for hospital services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**.

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

(6)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, [*2013*] **2015**, that will result in the collection occurring between December 15, [*2013*] **2015**, and the time all Medicaid cost settlements are finalized for that calendar

quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 3. Section 3, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 3. (1) Notwithstanding section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003**, the Director of [*Human Services*] **the Oregon Health Authority** shall reduce the rate of assessment imposed under section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003,** to the maximum rate allowed under federal law if the reduction is required to comply with federal law.

(2) If federal law requires a reduction in the rate of assessments, the director shall, after consulting with representatives of the hospitals that are subject to the assessments, first reduce the distribution of moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, by a corresponding amount.

SECTION 4. Section 6, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 6. (1) Any hospital that has paid an amount that is not required under sections 1 to 9**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003,** may file a claim for refund with the [*Department of Human Services*] **Oregon Health Authority**.

(2) Any hospital that is aggrieved by an action of the [*Department of Human Services*] **authority** or by an action of the Director of [*Human Services*] **the Oregon Health Authority** taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 5. Section 7, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 7. The [*Department of Human Services*] **Oregon Health Authority** may audit the records of any hospital in this state to determine compliance with sections 1 to 9**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003, and section 1 of this 2013 Act**. The [*department*] **authority** may audit records at any time for a period of five years following the date an assessment is due to be reported and paid under section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003**.

SECTION 6. Section 8, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 757, Oregon Laws 2005, is amended to read:

Sec. 8. Amounts collected by the [*Department of Human Services*] **Oregon Health Authority** from the assessments imposed under section 2, chapter 736, Oregon Laws 2003, shall be deposited in the Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003.

SECTION 7. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, and section 59, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of**:**

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003 [, *and*]**;**

(b) Funding services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**, including but not limited to[*:*]

[*(a)*] increasing reimbursement rates for inpatient and outpatient hospital services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**;

[*(b) Maintaining, expanding or modifying services for persons described in ORS 414.025 (3)(s);*]

[*(c) Maintaining or increasing the number of persons described in ORS 414.025 (3)(s) who are enrolled in the medical assistance program; and*]

[*(d)*] **(c) Making payments described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003;**

(d) Making distributions, as described in section 1 (4) of this 2013 Act, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2, chapter 736, Oregon Laws 2003; and

(e) Paying administrative costs incurred by the authority to administer **section 1 of this 2013 Act and** the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (3)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 8. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, and section 20, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, [*2009*] **2013**, and ending the earlier of September 30, [*2013*] **2015**, or the date on which the assessment no longer qualifies for federal [*matching funds*] **financial participation** under Title XIX **or XXI** of the Social Security Act.

SECTION 9. Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, and section 21, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 12. Sections 1 to 9, chapter 736, Oregon Laws 2003, **and section 1 of this 2013 Act** are repealed on January 2, [*2015*] **2017**.

SECTION 10. Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, and section 22, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, **and section 1 of this 2013 Act** by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [*2013*] **2015**.

SECTION 11. ORS 414.746 is amended to read:

414.746. (1) The Oregon Health Authority [*shall*] **may** establish an adjustment to the payments made to a coordinated care organization [*defined in section 9, chapter 867, Oregon Laws 2009*].

(2) The contracts entered into between the authority and coordinated care organizations [*must*] **may** include provisions that ensure that the adjustment to the payments established under subsection (1) of this section is distributed by the coordinated care organizations to hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups.

[*(3) The adjustment to the capitation rate paid to coordinated care organizations shall be established in an amount consistent with the legislatively adopted budget and the aggregate assessment imposed pursuant to section 2, chapter 736, Oregon Laws 2003.*]

SECTION 12. ORS 414.746 is repealed.

SECTION 13. (1) The Director of the Oregon Health Authority shall apply to the federal Centers for Medicare and Medicaid Services for any approval necessary to secure federal financial participation in the distributions described in section 9 (2)(d), chapter 736, Oregon Laws 2003, as amended by section 7 of this 2013 Act, and in using the payment methodology described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003, as amended by section 2 of this 2013 Act.

(2) The Director of the Oregon Health Authority shall immediately notify the Legislative Counsel upon receipt of federal approval or disapproval under this section.

SECTION 14. Section 15 of this 2013 Act is added to and made a part of ORS chapter 442.

SECTION 15. (1) The Legislative Assembly finds that:

(a) A significant amount of public and private funds are expended each year for long term care services provided to Oregonians;

(b) Oregon has established itself as the national leader in providing a choice of noninstitutional care to low income Oregonians in need of long term care services by developing an extensive system of home health care and community-based care; and

(c) Long term care facilities continue to provide critical services to some of Oregon's most frail and vulnerable residents with complex needs. Increasingly, long term care facilities are filling a need for transitional care between hospitals and home settings in a cost-effective manner, reducing the overall costs of long term care.

(2) The Legislative Assembly declares its support for collaboration among state agencies that purchase health services and private health care providers in order to align financial incentives with the goals of achieving better patient care and improved health status while restraining growth in the per capita cost of health care.

(3) It is the goal of the Legislative Assembly that the long term care facility bed capacity in Oregon be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veterans' Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013.

(4) In order to reduce the long term care facility bed capacity statewide, the Department of Human Services may permit an operator of a long term care facility to purchase another long term care facility's entire bed capacity if:

(a) The long term care facility bed capacity being purchased is not in an essential long term care facility; and

(b) The long term care facility's entire bed capacity is purchased and the seller agrees to surrender the long term care facility's license on the earlier of the date that:

(A) The last resident is transferred from the facility; or

(B) Is 180 days after the date of purchase.

(5) If a long term care facility's entire bed capacity is purchased, the facility may not admit new residents to the facility except in accordance with criteria adopted by the Department of Human Services by rule.

(6) Long term care bed capacity purchased under this section may not be transferred to another long term care facility.

(7) The Department of Human Services may convene meetings with representatives of entities that include, but are not limited to, long term care providers, nonprofit trade associations and state and local governments to collaborate in strategies to reduce long term care facility bed capacity statewide. Participation shall be on a voluntary basis. Meetings shall be held at a time and place that is convenient for the participants.

(8) The Department of Human Services may conduct surveys of entities and individuals specified in subsection (7) of this section concerning current long term care facility bed capacity and strategies for increasing future capacity.

(9) Based on the findings in subsection (1) of this section and the declaration expressed in subsection (2) of this section, the Legislative Assembly declares its intent to exempt from state antitrust laws and provide immunity from federal antitrust laws through the state action doctrine individuals and entities that engage in transactions, meetings or surveys described in subsections (4), (7) and (8) of this section that might otherwise be constrained by such laws.

(10) The Director of Human Services or the director's designee shall engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the individuals and entities acting pursuant to subsection (4), (7) or (8) of this section are acting in accordance with the legislative intent expressed in this section.

(11) The Director of Human Services or the director's designee, in consultation with the Long Term Care Ombudsman, shall engage in regional planning necessary to promote the safety and dignity of residents living in a long term care facility that surrenders its license under this section.

SECTION 16. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

[*(4) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.*]

[*(5)*] **(4)** "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(5) "Essential long term care facility" means an individual long term care facility that serves predominantly rural and frontier communities, as designated by the Office of Rural Health, and meets other criteria established by the Department of Human Services by rule.

(6) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(7) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(8) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(9) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(10)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(11) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(12) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(13) "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the [*Oregon Health*] authority by rule.

(14) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

(15) "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

(16) "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

(17) "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

(18) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period **in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013**.

(19) "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(20) "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

(21) "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

(22) "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

SECTION 17. ORS 442.315 is amended to read:

442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065**, and any long term care facility for which a license was surrendered under section 15 of this 2013 Act,** shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need. **The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.**

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.

SECTION 18. Section 18, chapter 736, Oregon Laws 2003, as amended by section 34, chapter 736, Oregon Laws 2003, section 7, chapter 757, Oregon Laws 2005, and section 10, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 18. [*(1)*] The Oregon Veterans' Home is exempt from the assessment imposed under section 16, chapter 736, Oregon Laws 2003.

[*(2) A waivered long term care facility is exempt from the long term care facility assessment imposed under section 16, chapter 736, Oregon Laws 2003.*]

[*(3) As used in this section, "waivered long term care facility" means:*]

[*(a) A long term care facility operated by a continuing care retirement community that is registered under ORS 101.030 and that admits:*]

[*(A) Residents of the continuing care retirement community; or*]

[*(B) Residents of the continuing care retirement community and nonresidents; or*]

[*(b) A long term care facility that is annually identified by the Department of Human Services as having a Medicaid recipient census that exceeds the census level established by the department for the year for which the facility is identified.*]

SECTION 19. Section 23, chapter 736, Oregon Laws 2003, as amended by section 8, chapter 757, Oregon Laws 2005, and section 11, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 23. Sections 15 to 22, chapter 736, Oregon Laws 2003, apply to long term care facility assessments imposed in calendar quarters beginning on or after November 26, 2003, and before July 1, [*2014*] **2020**.

SECTION 20. Section 24, chapter 736, Oregon Laws 2003, as amended by section 11, chapter 757, Oregon Laws 2005, and section 12, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 24. (1) The Long Term Care Facility Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Long Term Care Facility Quality Assurance Fund shall be credited to the fund.

(2) Amounts in the Long Term Care Facility Quality Assurance Fund are continuously appropriated to the Department of Human Services for the purposes of paying refunds due under section 20, chapter 736, Oregon Laws 2003, and funding long term care facilities, as defined in section 15,

chapter 736, Oregon Laws 2003, that are a part of the Oregon Medicaid reimbursement system.

(3) Funds in the Long Term Care Facility Quality Assurance Fund and the matching federal financial participation under Title XIX of the Social Security Act may be used to fund Medicaid-certified long term care facilities using only the reimbursement methodology described in [*subsection (4)*] **subsections (4) and (5)** of this section to achieve a rate of reimbursement greater than the rate in effect on June 30, 2003.

(4) The reimbursement methodology used to make additional payments to Medicaid-certified long term care facilities includes but is not limited to:

(a) Rebasing [*biennially, beginning on July 1 of each odd-numbered year*] **on July 1 of each year**;

[*(b) Adjusting for inflation in the nonrebasing year;*]

[*(c)*] **(b)** Continuing the use of the pediatric rate;

[*(d)*] **(c)** Continuing the use of the complex medical needs additional payment; **and**

[*(e)*] **(d)** Discontinuing the use of the relationship percentage, except when calculating the pediatric rate in paragraph [*(c)*] **(b)** of this subsection[*; and*]**.**

(5) In addition to the reimbursement methodology described in subsection (4) of this section, the department may make additional payments of $9.75 per resident who receives medical assistance to a long term care facility that purchased long term care bed capacity under section 15 of this 2013 Act on or after October 1, 2013, and on or before December 31, 2015. The payments may be made for a period of four years from the date of purchase. The department may not make additional payments under this section until the Medicaid-certified long term care facility is found by the department to meet quality standards adopted by the department by rule.

[*(f)*] **(6)(a)** [*Requiring*] The department [*of Human Services to*] **shall** reimburse costs **using the methodology described in subsections (4) and (5) of this section** at a rate not lower than [*the 63rd percentile ceiling*] **a percentile** of allowable costs for the [*biennium*] **period** for which the reimbursement is made.

(b) For the period beginning July 1, 2013, and ending June 30, 2016, the department shall reimburse costs at a rate not lower than the 63rd percentile of rebased allowable costs for that period.

(c) For each three-month period beginning on or after July 1, 2016, in which the reduction in bed capacity in Medicaid-certified long term care facilities is less than the goal established in section 15 of this 2013 Act, the department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 62nd percentile for a reduction of 1,350 or more beds.

(B) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(C) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(D) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(E) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(F) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(G) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(H) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(I) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(J) 53rd percentile for a reduction of 1 to 49 beds.

(7) A reduction in the percentile of allowable costs reimbursed under subsection (6) of

this section is not subject to ORS 410.555.

SECTION 21. Section 31, chapter 736, Oregon Laws 2003, as amended by section 9, chapter 757, Oregon Laws 2005, section 14, chapter 780, Oregon Laws 2007, and section 49, chapter 11, Oregon Laws 2009, is amended to read:

Sec. 31. Sections 15 to 22, 24 and 29, chapter 736, Oregon Laws 2003, are repealed on [*January 2, 2015*] **January 2, 2021**.

SECTION 22. ORS 442.015, as amended by section 16 of this 2013 Act, is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

[*(5) "Essential long term care facility" means an individual long term care facility that serves predominantly rural and frontier communities, as designated by the Office of Rural Health, and meets other criteria established by the Department of Human Services by rule.*]

[*(6)*] **(5)** "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

[*(7)*] **(6)** "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

[*(8)*] **(7)** "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

[*(9)*] **(8)** "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

[*(10)(a)*] **(9)(a)** "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

[*(11)*] **(10)** "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

[*(12)*] **(11)** "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

[*(13)*] **(12)** "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the authority by rule.

[*(14)*] **(13)** "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

[*(15)*] **(14)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental

or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(16)*] **(15)** "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(17)*] **(16)** "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(18)*] **(17)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period [*in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013*].

[*(19)*] **(18)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(20)*] **(19)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(21)*] **(20)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(22)*] **(21)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

SECTION 23. ORS 442.315, as amended by section 17 of this 2013 Act, is amended to read:

442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065[*, and any long term care facility for which a license was surrendered under section 15 of this 2013 Act,*] shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need.

The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the

circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.

SECTION 24. Section 24, chapter 736, Oregon Laws 2003, as amended by section 11, chapter 757, Oregon Laws 2005, section 12, chapter 780, Oregon Laws 2007, and section 20 of this 2013 Act, is amended to read:

Sec. 24. (1) The Long Term Care Facility Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Long Term Care Facility Quality Assurance Fund shall be credited to the fund.

(2) Amounts in the Long Term Care Facility Quality Assurance Fund are continuously appropriated to the Department of Human Services for the purposes of paying refunds due under section 20, chapter 736, Oregon Laws 2003, and funding long term care facilities, as defined in section 15, chapter 736, Oregon Laws 2003, that are a part of the Oregon Medicaid reimbursement system.

(3) Funds in the Long Term Care Facility Quality Assurance Fund and the matching federal financial participation under Title XIX of the Social Security Act may be used to fund Medicaid-certified long term care facilities using only the reimbursement methodology described in [*subsections (4) and (5)*] **subsection (4)** of this section to achieve a rate of reimbursement greater than the rate in effect on June 30, 2003.

(4) The reimbursement methodology used to make additional payments to Medicaid-certified long term care facilities includes but is not limited to:

(a) Rebasing on July 1 of each year;

(b) Continuing the use of the pediatric rate;

(c) Continuing the use of the complex medical needs additional payment; and

(d) Discontinuing the use of the relationship percentage, except when calculating the pediatric rate in paragraph (b) of this subsection.

[*(5) In addition to the reimbursement methodology described in subsection (4) of this section, the department may make additional payments of $9.75 per resident who receives medical assistance to a long term care facility that purchased long term care bed capacity under section 15 of this 2013 Act on or after October 1, 2013, and on or before December 31, 2015. The payments may be made for a period of four years from the date of purchase. The department may not make additional payments under this section until the Medicaid-certified long term care facility is found by the department to meet quality standards adopted by the department by rule.*]

[*(6)(a)*] **(5)(a)** The department shall reimburse costs using the methodology described in [*subsections (4) and (5)*] **subsection (4)** of this section at a rate not lower than a percentile of allowable costs for the period for which the reimbursement is made.

(b) For the period beginning July 1, 2013, and ending June 30, 2016, the department shall reimburse costs at a rate not lower than the 63rd percentile of rebased allowable costs for that period.

(c) For each three-month period beginning on or after July 1, 2016, in which the reduction in bed capacity in Medicaid-certified long term care facilities is less than [*the goal established in section 15 of this 2013 Act*] **1,500 in bed capacity statewide that existed on the effective date of this 2013 Act**, the department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 62nd percentile for a reduction of 1,350 or more beds.

(B) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(C) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(D) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(E) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(F) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(G) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(H) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(I) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(J) 53rd percentile for a reduction of 1 to 149 beds.

[*(7)*] **(6)** A reduction in the percentile **ceiling** of allowable costs reimbursed under subsection [*(6)*] **(5)** of this section is not subject to ORS 410.555.

SECTION 25. (1) Section 1 of this 2013 Act and the amendments to ORS 414.746 and sections 2, 3, 6, 7, 8, 9, 10, 12 and 13, chapter 736, Oregon Laws 2003, by sections 2 to 11 of this 2013 Act become operative on the date that the Director of the Oregon Health Authority notifies the Legislative Counsel that the director received federal approval as described in section 13 of this 2013 Act.

(2) The repeal of ORS 414.746 by section 12 of this 2013 Act becomes operative April 1, 2014.

SECTION 26. (1) The amendments to section 18, chapter 736, Oregon Laws 2003, by section 18 of this 2013 Act become operative January 1, 2014.

(2) The amendments to ORS 442.015 and 442.315 and section 24, chapter 736, Oregon Laws 2003, by sections 22, 23 and 24 of this 2013 Act become operative June 30, 2020.

SECTION 27. Section 15 of this 2013 Act is repealed June 30, 2020.

SECTION 28. This 2013 Act takes effect on the 91st day after the date on which the 2013 regular session of the Seventy-seventh Legislative Assembly adjourns sine die.