Senate Bill 568

Sponsored by Senators MONNES ANDERSON, COURTNEY, FERRIOLI, Representatives MCLANE, KOTEK; Senators BATES, JOHNSON, KNOPP, KRUSE, STEINER HAYWARD, WINTERS, Representatives CONGER, FREEMAN, GREENLICK, HOYLE, KENY-GUYER, NATHANSON, THOMPSON

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.**

Requires Oregon Health Authority to adopt dispute resolution process to resolve disputes involving termination, extension or renewal of contract between health care entity and coordinated care organization. Extends sunset on provision governing reimbursement of hospitals by coordinated care organizations.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care contracting; amending ORS 414.635 and section 7, chapter 886, Oregon Laws 2009; and declaring an emergency.

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

SECTION 1. ORS 414.635, as amended by section 9, chapter 602, Oregon Laws 2011, and section 5, chapter 8, Oregon Laws 2012, is amended to read:

414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

(a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

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.

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

(3) Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7)**(a)** The authority shall adopt by rule a process for resolving disputes involving [*an*]**:**

(A) A health care entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section.

(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

(b) The [*process*] **processes adopted under this subsection** must include the use of an independent third party arbitrator.

(8) A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.

SECTION 2. Section 7, chapter 886, Oregon Laws 2009, is amended to read:

Sec. 7. ORS 414.743 is repealed on January 2, [*2014*] **2016**.

SECTION 3. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.
