Senate Bill 609

Sponsored by Senator STEINER HAYWARD; Senators BEYER, ROBLAN, SHIELDS, Representatives LIVELY, NOSSE

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 convene learning collaborative to develop payment method to support provision of care through patient centered primary care homes. Specifies membership of collaborative. Requires Department of Consumer and Business Services to adopt, to greatest extent practicable, method developed by collaborative for reimbursement of patient centered primary care homes by insurers and third party administrators.

Requires Oregon Health Authority to request federal approval necessary to implement payment method for medical assistance program.

Gives collaborative state antitrust immunity for three years.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to payments for health care; creating new provisions; amending ORS 413.260, 442.210, 442.466 and 442.993; and declaring an emergency.

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

SECTION 1. (1) As used in this section:

(a) "Payer" includes insurers, third party administrators, the Oregon Health Authority, coordinated care organizations, health care service contractors, multiple employer welfare associations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

(b) "Risk-stratified care management" means intensive care management in which patients with serious or multiple medical conditions receive the level of care and medications that they need.

(2) The Oregon Health Authority shall convene a learning collaborative for the purpose of developing one or more methods of reimbursement that will direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in patient centered primary care homes. The authority shall employ the methods in reimbursing patient centered primary care homes for health care provided to recipients of medical assistance.

(3) The collaborative shall include representatives of all of the following:

(a) Each payer that volunteers to participate in the collaborative.

(b) Third party administrators.

(c) A statewide professional association for family physicians.

(d) A statewide professional association for physicians.

(e) A statewide professional association for nurses.

(f) A statewide professional association for pediatricians.

(g) A statewide organization that represents hospitals and health systems.

(h) Patient centered primary care home providers.

(i) The Department of Consumer and Business Services.

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.

(j) Other entities that the authority deems appropriate.

(4) The authority shall invite a representative of the Centers for Medicare and Medicaid Services to participate in the collaborative.

(5) One of the methods of reimbursement developed by the collaborative under subsection (2) of this section must include innovation payments to each patient centered primary care home. The innovation payments must meet all of the following criteria:

(a) The innovation payments are specific amounts paid to a patient centered primary care home on a per patient basis for each month that the patient chooses to receive care through the patient centered primary care home. The patient's choice to receive care through the patient centered primary care home must be confirmed by the patient's verbal or written affirmation. The payments shall be:

(A) Considered payments for clinical care and not for administrative expenses; and

(B) Paid in addition to any reimbursement that the patient centered primary care home receives from a payer in fee-for-service payments, capitation payments or other contracted methods of reimbursement. A payer may not decrease the reimbursement paid to a patient centered primary care home to offset the cost of the innovation payment.

(b) The innovation payments are based upon the classification of a patient centered primary care home by the patient centered primary care home program. If the authority modifies the classification system or requirements for patient centered primary care homes, the collaborative shall modify the innovation payments to reflect the new classifications or requirements.

(c) The innovation payments must be utilized by a patient centered primary care home to pay the cost of health care services provided by a clinic or a provider that participates in the patient centered primary care home.

(d) The innovation payments must compensate a patient centered primary care home for the behavioral health services and other types of services that have no prescribed billing codes or are not otherwise reimbursed by payers, including:

(A) Risk-stratified care management;

(B) Patient access to care, and provider access to patient data, at all times;

(C) Enhanced continuity of care;

(D) Preventive care and proactive care for chronic conditions;

(E) Active engagement of the patient and caregiver in the patient's care;

(F) Coordination of care among all of a patient's health care providers; and

(G) Leadership and team engagement in the improvement of health care.

(6) The authority may require patient centered primary care homes that receive innovation payments to submit administratively simple budgeting and activity information regarding their use of innovation payments.

(7) The collaborative shall annually review the innovation payment method and payment amounts and make adjustments as needed.

(8) All methods of reimbursement developed by the collaborative must adequately compensate patient centered primary care homes for the services that the patient centered primary care home agrees to provide.

(9) The collaborative shall establish quality and outcome benchmarks for evaluating the effectiveness of the innovation payments and other methods of reimbursement developed by the collaborative in providing financial stability to patient centered primary care homes. The

benchmarks must be aligned with outcome and quality measures adopted by the authority for coordinated care organizations, to the greatest extent practicable. The authority shall conduct an evaluation and report the results of its evaluation, in the manner provided in ORS 192.245, to each regular session of the Legislative Assembly.

(10) The authority may contract with a public or private entity to facilitate the work of the collaborative described in this section and may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body or agency or from any other public or private corporation or person for the purpose of establishing and maintaining the collaborative.

SECTION 2. Section 3 of this 2015 Act is added to and made a part of the Insurance Code.

SECTION 3. (1) The Department of Consumer and Business Services shall, to the greatest extent practicable, adopt by rule the innovation payment method developed by the learning collaborative under section 1 of this 2015 Act.

(2) All insurers and third party administrators must use the innovation payment method adopted by the department in this section in reimbursing patient centered primary care homes.

SECTION 4. The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate reimbursement methods that align incentives in support of patient centered primary care homes is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, the learning collaborative convened and associated methods of reimbursement developed under section 1 of this 2015 Act that might otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws, including, but not limited to, agreements among competing health care providers or health carriers regarding the prices of specific levels of reimbursement for health care services.

SECTION 5. Care management payments made to patient centered primary care homes participating in the Comprehensive Primary Care Initiative conducted by the Centers for Medicare and Medicaid Services under 42 U.S.C. 1315a or other care management payments may be subtracted from innovation payments made to the participants by payers under section 3 of this 2015 Act.

SECTION 6. The learning collaborative described in section 1 of this 2015 Act shall have its first meeting no later than October 1, 2015.

SECTION 7. The Oregon Health Authority shall define the guidelines of participation in, and the function of, the collaborative described in section 1 of this 2015 Act no later than September 1, 2015.

SECTION 8. The Oregon Health Authority shall amend the state Medicaid plan or seek other approval from the Centers for Medicare and Medicaid Services as required to ensure federal financial participation in the innovation payments made to patient centered primary care homes and in other methods of reimbursement developed by the learning collaborative under section 1 of this 2015 Act.

SECTION 9. ORS 442.210 is amended to read:

442.210. (1) There is established in the [*Office for Oregon Health Policy and Research*] **Oregon Health Authority** the patient centered primary care home program. Through this program, the [*office*] **authority** shall:

(a) Define core attributes of the patient centered primary care home to promote a reasonable level of consistency of services provided by patient centered primary care homes in this state. In defining core attributes related to ensuring that care is coordinated, the [*office*] **authority** shall focus on determining whether these patient centered primary care homes offer comprehensive primary care, including prevention and disease management services;

(b) Establish a simple and uniform process to identify patient centered primary care homes that meet the core attributes defined by the [*office*] **authority** under paragraph (a) of this subsection;

(c) Develop uniform quality measures that build from nationally accepted measures and allow for standard measurement of patient centered primary care home performance;

(d) Develop uniform quality measures for acute care hospital and ambulatory services that align with the patient centered primary care home quality measures developed under paragraph (c) of this subsection; and

(e) Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.

(2)(a) The Director of the Oregon Health Authority shall appoint an advisory committee to advise the [*office*] **authority** in carrying out subsection (1) of this section.

(b) The director shall appoint to the advisory committee 15 individuals who represent a diverse constituency and are knowledgeable about patient centered primary care home delivery systems and health care quality.

(c) Members of the advisory committee are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the [*office*] **authority** for the purposes of the advisory committee.

(d) The advisory committee shall use public input to guide policy development.

(3) The [*office*] **authority** will also establish, as part of the patient centered primary care home program, [*a*] **the** learning collaborative **described in section 1 of this 2015 Act.** [*in which state agencies, private health insurance carriers, third party administrators and patient centered primary care homes can:*]

[*(a) Share information about quality improvement;*]

[*(b) Share best practices that increase access to culturally competent and linguistically appropriate care;*]

[*(c) Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care;*]

[*(d) Coordinate efforts to develop and test methods to align financial incentives to support patient centered primary care homes;*]

[*(e) Share best practices for maximizing the utilization of patient centered primary care homes by individuals enrolled in medical assistance programs, including culturally specific and targeted outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;*]

[*(f) Coordinate efforts to conduct research on patient centered primary care homes and evaluate strategies to implement the patient centered primary care home to improve health status and quality*

and reduce overall health care costs; and]

[*(g) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services.*]

[*(4) The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate reimbursement methods to align incentives in support of patient centered primary care homes is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and associated payment reforms designed and implemented under subsection (3) of this section that might otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the prices of specific levels of reimbursement for health care services.*]

[*(5) The office may contract with a public or private entity to facilitate the work of the learning collaborative described in subsection (3) of this section and may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body or agency or from any other public or private corporation or person for the purpose of establishing and maintaining the collaborative.*]

SECTION 10. ORS 442.466 is amended to read:

442.466. (1) The [*Administrator of the Office for Oregon Health Policy and Research*] **Oregon Health Authority** shall establish and maintain a program that requires reporting entities to report health care data for the following purposes:

(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

(b) Identifying the demands for health care.

(c) Allowing health care policymakers to make informed choices.

(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

(e) Comparing the costs and effectiveness of various treatment settings and approaches.

(f) Providing information to consumers and purchasers of health care.

(g) Improving the quality and affordability of health care and health care coverage.

(h) Assisting the [*administrator*] **authority** in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

(j) Implementing, adjusting and evaluating the innovation payments and other methods of reimbursement developed by the learning collaborative under section 1 of this 2015 Act.

(2) The [*Administrator of the Office for Oregon Health Policy and Research*] **authority** shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

(A) Requiring the use of unique patient and provider identifiers;

(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

(C) Establishing enrollment thresholds below which reporting will not be required.

(b) Establish the types of data to be reported under this section, including but not limited to:

(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the [*administrator*] **authority** to be necessary to carry out the purposes of this section; and

(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the [*Administrator of the Office for Oregon Health Policy and Research*] **authority** the health care data described in subsection (2) of this section.

(4) The [*Administrator of the Office for Oregon Health Policy and Research*] **authority** shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

(5) The [*Administrator of the Office for Oregon Health Policy and Research*] **authority** shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

(6) The [*Administrator of the Office for Oregon Health Policy and Research*] **authority** may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the [*Office for Oregon Health Policy and Research*] **authority**.

(7) The [*Administrator of the Office for Oregon Health Policy and Research*] **Director of the Oregon Health Authority** shall facilitate a collaboration between the Department of Human Services, the Oregon Health Authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the Office **for Oregon Health Policy and Research** under ORS 442.120 and 442.400 to 442.463. The [*administrator*] **director**, in consultation with interested stakeholders, shall:

(a) Formulate the data sets that will be included in the system;

(b) Establish the criteria and procedures for the development of limited use data sets;

(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

(d) Establish a time frame for the creation of the comprehensive health care information system.

(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

(b) Shall be available to Oregon programs for quality in health care for use in improving health

care in Oregon, subject to rules prescribed by the [*Administrator of the Office for Oregon Health Policy and Research*] **authority** conforming to state and federal privacy laws or limiting access to limited use data sets;

(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

(d) May not disclose trade secrets of reporting entities.

(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.

SECTION 11. ORS 442.993 is amended to read:

442.993. (1) Any reporting entity that fails to report as required in ORS 442.466 or rules of the [*Office for Oregon Health Policy and Research*] **Oregon Health Authority** adopted pursuant to ORS 442.466 may be subject to a civil penalty.

(2) The [*Administrator of the Office for Oregon Health Policy and Research*] **authority** shall adopt a schedule of penalties not to exceed $500 per day of violation, determined by the severity of the violation.

(3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and conditions as the [*administrator*] **authority** considers proper and consistent with the public health and safety.

(5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose of rate determination or for reimbursement by a third-party payer.

SECTION 12. ORS 413.260 is amended to read:

413.260. (1) The Oregon Health Authority, in collaboration with health insurers and purchasers of health plans including the Public Employees' Benefit Board, the Oregon Educators Benefit Board and other members of the patient centered primary care home learning collaborative and the patient centered primary care home program advisory committee, shall:

(a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans for:

(A) Receiving care through patient centered primary care homes that meet the core attributes established in ORS 442.210;

(B) Seeking preventative and wellness services;

(C) Practicing healthy behaviors; and

(D) Effectively managing chronic diseases.

(b) Develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient centered primary care homes in underserved communities.

(2) The authority shall focus on patients with chronic health conditions in developing strategies under this section.

(3) The authority, in collaboration with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, shall establish uniform standards for contracts with health benefit plans providing coverage to public employees to promote the provision of patient centered primary care homes, especially for enrollees with chronic medical conditions, that are consistent with the uniform quality measures established by the [*Office for Oregon Health Policy and Research*] **authority** under ORS 442.210 (1)(c).

(4) The standards established under subsection (3) of this section may direct health benefit plans to provide incentives to primary care providers who serve vulnerable populations to partner with health-focused community-based organizations to provide culturally specific health promotion and disease management services.

SECTION 13. Section 3 of this 2015 Act applies to policies or certificates of health insurance issued or renewed on or after January 1, 2016.

SECTION 14. (1) Section 4 of this 2015 Act is repealed 36 months after the effective date of this 2015 Act.

(2) Section 5 of this 2015 Act is repealed January 2, 2017.

SECTION 15. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.