HB 4018-15
(LC 25)
2/7/18 (LHF/ps)

Requested by HOUSE COMMITTEE ON HEALTH CARE

PROPOSED AMENDMENTS TO
HOUSE BILL 4018

On page 1 of the printed bill, line 2, after "414.625" insert "and 414.653".

After line 7, insert:

"SECTION 3. (1) No later than December 31, 2024, the Oregon Health Authority shall develop a plan to move from a predominantly fee-for-service payment methodology that reimburses providers in the medical assistance program based on the quantity of services to a payment methodology for providers based on the quality of services.

"(2) The plan must, consistent with the terms and conditions of the demonstration project approved by the federal Centers for Medicare and Medicaid Services:

"(a) Define payment methodologies that align with the payment models developed by the federal Center for Medicare and Medicaid Innovation;

"(b) Establish benchmarks for increasing the use of alternative payment methodologies; and

"(c) Allow coordinated care organizations to phase in the use of alternative payment methodologies over the term of the coordinated care organization's contract with the authority.

"(3) The authority shall work with each coordinated care organization to develop an individualized plan to move the coordinated care organization toward greater utilization of alternative payment meth-

odologies. The plan must describe how the coordinated care organization and its contracted providers will meet the benchmarks established by the authority under subsection (2) of this section for the utilization of alternative payment methodologies.".

In line 8, delete "3" and insert "4".

On page 4, line 9, delete "4" and insert "5".

On page 6, after line 38, insert:

"**SECTION 6.** ORS 414.653 is amended to read:

"414.653. (1) The Oregon Health Authority shall [*encourage*] **require** coordinated care organizations to use alternative payment methodologies that:

"(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

"(b) Hold organizations and providers responsible for the efficient delivery of quality care;

"(c) Reward good performance;

"(d) Limit increases in medical costs; and

"(e) Use payment structures that create incentives to:

"(A) Promote prevention;

"(B) Provide person centered care; and

"(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes and behavioral health homes.

"(2) The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

"(3) A coordinated care organization that participates in a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar alternative payment methodologies to all patient centered primary

care homes identified in accordance with ORS 413.259 that serve members of the coordinated care organization.

"(4) The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

"(5) If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

"(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

"(b) Reimbursed by a coordinated care organization.

"(6)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

"(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

"(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

"(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the re-

imbursement specified in paragraph (a) of this subsection.

"(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

"(7) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

"SECTION 7. Section 3 of this 2018 Act is repealed on January 2, 2026.

"SECTION 8. The amendments to ORS 414.653 by section 6 of this 2018 Act become operative on January 1, 2025.".

In line 39, delete "5" and insert "9".
