SB 1041-A8
(LC 2605)
5/16/19 (LHF/ps)

Requested by Representative SALINAS

PROPOSED AMENDMENTS TO
A-ENGROSSED SENATE BILL 1041

On page 1 of the printed A-engrossed bill, line 3, delete "and 414.625" and insert ", 414.625, 414.651 and 414.652".

On page 4, delete lines 15 through 17 and insert:

"SECTION 11. (1) A coordinated care organization shall have an annual audit conducted by an independent certified public accountant and shall file an audited financial report annually with the Oregon Health Authority by June 30 following the end of the period to which the report applies. The annual audited financial report shall disclose:

"(a) The financial position of the coordinated care organization as of the end of the most recent calendar year; and

"(b) The results of the coordinated care organization's operations, cash flows and changes in capital, surplus and reserves for the year just ended.

"(2) The authority shall adopt the following rules as needed for carrying out the requirements of this section prescribing the:

"(a) Required contents and format of the audited financial report.

"(b) Requirements for filing the report.

"(c) Requirements applicable to qualifications and designation of certified public accountants for purposes of audits under this section, which may include limitations on length of service for certified public accountants and may permit recognition of accountants comparably

qualified under the laws of another country.

"(d) Requirements applicable to evaluation of the accounting procedures of a coordinated care organization and its system of internal control by a certified public accountant.

"(e) Standards governing the scope and preparation of the audit.

"(f) Requirements and procedures relating to the reporting of the adverse financial condition of a coordinated care organization by a certified public accountant.

"(g) Requirements and procedures relating to the reporting of significant deficiencies for internal controls of a coordinated care organization.

"(h) Exemptions.

"(i) Any other matter that the authority determines to be needed for preparation of or inclusion in the financial report.".

On page 21, delete lines 13 through 43 and insert:

"(b) ORS 731.504;

"(c) ORS 731.508;

"(d) ORS 731.509 (1) to (8) and (10);

"(e) ORS 731.574 (1) to (5);

"(f) ORS 731.730;

"(g) ORS 731.988;

"(h) ORS 732.235;

"(i) ORS 732.517 to 732.546, other than ORS 732.527, 732.531 and 732.541;

"(j) ORS 732.548;

"(k) ORS 732.549;

"(L) ORS 732.551;

"(m) ORS 732.552;

"(n) ORS 732.553;

"(o) ORS 732.554;

"(p) ORS 732.556;

"(q) ORS 732.558;

"(r) ORS 732.564;

"(s) ORS 732.566;

"(t) ORS 732.567;

"(u) ORS 732.568;

"(v) ORS 732.569;

"(w) ORS 732.574;

"(x) ORS 732.576;

"(y) ORS 732.578;

"(z) ORS 732.592;

"(aa) ORS 733.010 to 733.050;

"(bb) ORS 733.140 to 733.170;

"(cc) ORS 733.510 to 733.680;

"(dd) ORS 733.695 to 733.780; and

"(ee) ORS 734.014.

"(3) Rules adopted by the authority in accordance with ORS 731.385 that establish minimum standards for risk-based capital may not require a coordinated care organization to take preventive or corrective measures to increase the coordinated care organization's capital, surplus or reserves to achieve more than 200 percent of the minimum risk-based capital.

"SECTION 54. (1) As used in this section:

"(a) 'Coordinated care organization' has the meaning given that term in ORS 414.025.

"(b) 'Medical assistance' has the meaning given that term in ORS 414.025.

"(c) 'Related party' means an entity that:

"(A) Provides administrative services or financing to a coordinated care organization directly or through one or more unrelated parties; and

"(B) Is associated with the coordinated care organization by any

form of affiliation, control or investment.

"(d) 'Risk accepting entity' means an entity that:

"(A) Enters into an arrangement or agreement with a coordinated care organization to provide health services to members of the coordinated care organization;

"(B) Assumes the financial risk of providing health services to medical assistance recipients; and

"(C) Is compensated on a prepaid capitated basis for providing health services to members of a coordinated care organization.

"(e) 'Risk adjusted rate of growth' means the percentage change in a coordinated care organization's health care expenditures from one year to the next year, taking into account the variability in the relative health status of the members of the coordinated care organization from one year to the next year.

"(2) It is the intent of the Legislative Assembly that the expenditures of a coordinated care organization serving medical assistance recipients be fully transparent and available to the public.

"(3) The Oregon Health Authority shall make readily available to the public on an easily accessible website, and shall annually report to the Legislative Assembly, the following information for the preceding calendar year regarding each coordinated care organization contracting with the authority:

"(a) All financial distributions by the coordinated care organization to shareholders, equity members, parent companies or any related parties.

"(b) The annual audited financial statements of the coordinated care organization filed with the authority under section 11 of this 2019 Act.

"(c) The annual risk adjusted rate of growth for the coordinated care organization.

"(d) Every report submitted by the coordinated care organization to the authority as required in the coordinated care organization's contract with the authority, except for reports containing information protected from disclosure by state or federal law or protected from disclosure as a trade secret, as defined in ORS 192.345, including compensation paid to providers by a coordinated care organization.

"(4) The information described in subsection (3) of this section must be provided for each calendar year beginning with 2020.

"(5) The authority shall post the information described in subsection (3) of this section no later than August 1 of the year following the year for which the information is reported.

"SECTION 54a. The Oregon Health Authority shall report all information described in section 54 of this 2019 Act that is made available to the public in a manner that is uniform and sufficiently detailed to ensure accurate comparisons of the data between coordinated care organizations.

"SECTION 54b. The Oregon Health Authority shall make the information described in section 54 of this 2019 Act available to the public, as required by section 54 (3) of this 2019 Act, no later than August 1, 2021.

"SECTION 54c. (1) The Oregon Health Authority shall convene an advisory group consisting of one representative from each coordinated care organization that contracts with the authority. The advisory group shall recommend standards for reconciling the differences between the financial reporting required by the National Association of Insurance Commissioners and the financial reporting that the authority needs to regulate coordinated care organizations as required by state and federal law.

"(2) No later than September 15, 2020, the authority shall submit a report of the advisory group's recommendations to the interim com-

mittees of the Legislative Assembly related to health. The report must include:

"(a) Recommendations for reducing redundant or duplicative reporting requirements; and

"(b) Standard templates for any reporting required by the authority of financial information that is in addition to the financial information reported in the National Association of Insurance Commissioner's financial reporting requirements.".

In line 44, delete "54" and insert "54d".

On page 24, line 3, delete "(1) and" and after "732.225" insert ", 732.230".

On page 28, after line 43, insert:

"SECTION 59. ORS 414.651 is amended to read:

"414.651. (1)[*(a)*] The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, chemical dependency and mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

"[*(b)*] **(2)** The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.625. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

"[*(c)*] **(3)(a)** The authority shall establish financial reporting requirements for coordinated care organizations**, consistent with ORS 731.574 and section 11 of this 2019 Act, no less than 90 days before the beginning of the reporting period**. The authority shall prescribe [*a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each coordinated care organization and*] **requirements and procedures for financial reporting** that:

"(A) [*Enables*] **Enable** the authority to verify that the coordinated care

organization's **capital, surplus,** reserves and other financial resources are adequate to ensure against the risk of insolvency; [*and*]

"(B) [*Includes*] **Include** information on the three highest executive salary and benefit packages of each coordinated care organization**;**

"(C) Require quarterly reports to be filed with the authority by May 31, August 31 and November 30;

"(D) In addition to the annual audited financial statement required by section 11 of this 2019 Act, require an annual report to be filed with the authority by April 30 following the end of the period for which data is reported; and

"(E) Align, to the greatest extent practicable, with the National Association of Insurance Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations that are also regulated by the Department of Consumer and Business Services or have affiliates that are regulated by the department.

"**(b) The authority shall provide information to coordinated care organizations about the reporting standards of the National Association of Insurance Commissioners and provide training on the reporting standards to the staff of coordinated care organizations who will be responsible for compiling the reports.**

"[*(d)*] **(4)** The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

"[*(e)*] **(5)** The authority shall require compliance with the provisions of [*paragraphs (c) and (d) of this subsection*] **subsections (3) and (4) of this section** as a condition of entering into a contract with a coordinated care organization. A coordinated care organization, contractor or provider that fails to comply with [*paragraph (c) or (d) of this subsection*] **subsection (3) or (4) of this section** may be subject to sanctions, including but not limited

to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.

"[*(f)(A)*] **(6)(a)** The authority shall adopt rules and procedures to ensure that if a rural health clinic provides a health service to a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care organization, the rural health clinic receives total aggregate payments from the member's coordinated care organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

"[*(B)*] **(b)** 'Rural health clinic,' as used in this [*paragraph*] **subsection**, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

"[*(2)*] **(7)** The authority may contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

"[*(3)*] **(8)** [*As provided in subsections (1) and (2) of this section,*] The aggregate expenditures by the authority for health services provided pursuant to ORS [*414.631, 414.651 and 414.688 to 414.745*] **chapter 414** may not exceed the total dollars appropriated for health services under ORS [*414.631, 414.651 and 414.688 to 414.745*] **chapter 414**.

"[*(4)*] **(9)** Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS [*414.631, 414.651, 414.654 and 414.688 to 414.745*] **chapter 414** in forming consortiums or in otherwise entering into

contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

"[*(5)*] **(10)** Health care providers contracting to provide services under ORS [*414.631, 414.651 and 414.688 to 414.745*] **chapter 414** shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

"[*(6)*] **(11)** A coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

"[*(7)*] **(12)** Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

"[*(8)*] **(13)** Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

"(a) Grievances and appeals; and

"(b) Availability and accessibility of services provided to members.

"[*(9)*] **(14)** A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member.

"SECTION 60. ORS 414.652, as amended by section 5, chapter 49, Oregon Laws 2018, is amended to read:

"414.652. (1) As used in this section:

"(a) 'Benefit period' means a period of time, shorter than the five-year contract term, for which specific terms and conditions in a contract between

a coordinated care organization and the Oregon Health Authority are in effect.

"(b) 'Renew' means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

"(2) A contract entered into between the authority and a coordinated care organization under ORS 414.625 (1):

"(a) Shall be for a term of five years;

"(b) Except as provided in subsection (4) of this section, may not be amended more than once in each 12-month period; and

"(c) May be terminated by the authority if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

"(3) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.

"(4) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

"(a) The authority and the coordinated care organization mutually agree to amend the contract; or

"(b) Amendments are necessitated by changes in federal or state law.

"(5) Except as provided in subsection (7) of this section, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization.

"(6) An amendment to a contract may apply retroactively only if:

"(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

"(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services.

"**(7) If an amendment to a contract under subsection (6)(b) of this section or other circumstances arise that result in a claim by the authority for the recovery of amounts previously paid to a coordinated care organization by the authority, the authority shall ensure that the recovery does not have a material adverse effect on the coordinated care organization's ability to maintain the required minimum amounts of risk-based capital.**

"[*(7)*] **(8)** No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

"[*(8)*] **(9)** A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection [*(7)*] **(8)** of this section. Except as provided in subsections [*(9) and (10)*] **(10) and (11)** of this section, a refusal to renew terminates the contract at the end of the benefit period.

"[*(9)*] **(10)** The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

"(a) Notified each of its members and contracted providers of the termination of the contract;

"(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

"(c) Provided to the authority a plan for closing out its coordinated care

organization business.

"[*(10)*] **(11)** The authority may waive compliance with the deadlines in subsections [*(8) and*] (9) **and (10)** of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.".