A-Engrossed
House Bill 2878

Ordered by the House April 7
Including House Amendments dated April 7

Sponsored by Representative DEXTER, Senator ANDERSON, Representative REYNOLDS; Representative BOWMAN (Presession filed.)

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.

Establishes Aligning for Health Pilot Program, administered by Oregon Health Authority, to test alternative methods for payment for health care. Prescribes requirements for pilot and phases of implementation. **Exempts participants in program from requirement to obtain authority's approval for acquisitions and mergers.**

A BILL FOR AN ACT

Relating to paying for health care.

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

SECTION 1. (1) The Aligning for Health Pilot Program is established to be administered by the Oregon Health Authority. The goals of the program are to:

(a) Establish more predictable, aligned payment models, metrics and other expectations for providers regardless of the payer;

(b) Increase the numbers of providers receiving population-based payments that are tied to health outcomes;

(c) Reward health systems for keeping people healthy and containing costs;

(d) Give health systems and providers flexibility to be more innovative in how they deliver care and address the complex drivers of health; and

(e) Provide more equitable and meaningful access to quality health services and better health outcomes.

(2) As used in this section:

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

(b) "Global budget" means a financial arrangement that establishes an annual, predetermined total cost of health care for a defined population, calculated based on the health of the population, defined provider reimbursement rates, covered benefits, geographic location and priorities for addressing social determinants of health. A global budget is not recalculated based on the prior year's actual spending but increases at a defined rate of growth.

(c) "Health equity fund" means a program in which multiple payers invest collectively in a fund that finances community-based interventions targeting social issues such as food insecurity, housing instability, transportation and structural racism and the investments are then distributed equitably across all payers.

(d) "Payer" includes:

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.

(A) Insurance carriers.

(B) Coordinated care organizations.

(C) Third party administrators.

(D) Individuals purchasing insurance on or off of the health insurance exchange.

(E) Government insurance programs including Medicaid and Medicare.

(e) "Purchaser" includes:

(A) Purchasers of commercial health insurance.

(B) Private employer groups.

(C) The Public Employees' Benefit Board.

(D) The Oregon Educators Benefit Board.

(f) "Risk-adjust" means to make a modification to a payment to account for the provision of care to populations with higher needs and the expected utilization of the populations.

(g) "Risk corridors" means an established floor for losses and a cap on gains to protect against inaccurate rate setting.

(h) "Risk stabilization fund" means a multiyear risk pool that allows provider gains above a certain threshold to be placed in a reserve account to be retained for future periods when the provider experiences unfavorable financial results.

(i) "Stop-loss" means a process for providing payments to payers or providers for treatment costs that exceed a certain threshold.

(j) "Value-based payment" means a reimbursement methodology that makes performance-based adjustments to a base payment to hold health care providers financially accountable for improving quality and lowering health care costs.

(3) In the first phase of the Aligning for Health Pilot Program, the Oregon Health Authority shall complete the planning for the launch of the program by:

(a) Hiring program staff and working collaboratively with the Public Employees' Benefit Board and the Oregon Educators Benefit Board on the issuance of external contracts;

(b) Conducting legal, actuarial and regulatory analyses;

(c) Beginning to engage with payers, purchasers, community-based organizations and providers to gauge interest in participation in the program; and

(d) Identifying one or more potential regions where the program may begin.

(4) In identifying regions to be included in the program, priority shall be given to regions that meet the following criteria:

(a) Contain 5,000 to 30,000 potential enrollees in commercial insurance and in health plans offered by the Public Employees' Benefit Board and the Oregon Educators Benefit Board combined;

(b) Be defined primarily based on primary care services areas;

(c) Have an above average percentage of insured lives;

(d) Have above average number of residents with high social needs and substantial health inequities;

(e) Have community-based organizations and other entities with experience in addressing social determinants of health and health equity;

(f) Be areas where there are likely to be payers, purchasers, community-based organizations and providers that are interested in participating in the program; and

(g) Contain a relatively concentrated number of providers and payers to make the program more feasible administratively and logistically and to facilitate the providers' adapta-

tion to the payment model.

(5) In the second phase of the program, the authority shall:

(a) Finalize the risk mitigation strategies to be used in the program, including by establishing a health equity fund. The program must phase in the implementation of downside risk for safety net providers and smaller organizations serving vulnerable populations consistent with the principles of the Value-Based Payment Compact. Other risk mitigation strategies may include, but are not limited to, one or more of the following:

(A) Use of the Oregon Reinsurance Program or stop-loss;

(B) Risk corridors; and

(C) A risk stabilization fund;

(b) Engage providers in target areas by providing technical support funded by the authority for financial and actuarial simulation of the potential financial risk to providers if they choose to participate in the program, prioritizing providers with value-based payment experience;

(c) Open a request for proposal developed in partnership with purchasers that includes:

(A) Standardized quality and outcome performance measures; and

(B) Features to address and reduce health inequities in the regions;

(d) Solicit employer groups and other payers, especially those that are signatories to the Valued-Based Payment Compact; and

(e) Award individual three-year contracts to include the Public Employees' Benefit Board members, the Oregon Educators Benefit Board members and one or more commercial payers.

(6) In the third phase of the program, the authority shall launch the program and thereafter may add additional regions and participants.

(7)(a) Payers participating in the program shall:

(A) Sign on to the Value-Based Payment Compact;

(B) Stay within the global budget established by the authority and share risk with providers using mutually negotiated value-based payment agreements;

(C) Agree to a fixed rate of growth in the global budget; and

(D) Partner with coordinated care organizations or community-based organizations operating in the region.

(b) Payers may be required to invest in a set percentage of total revenue toward social determinants of health and annually report how the moneys were spent.

(c) Payers participating in the program are exempt from the requirements of ORS 415.501 while they are participating.

(8) Providers participating in the program:

(a) Generally assume accountability for a defined group of patients;

(b) Bear financial risk for spending targets;

(c) Are eligible for bonuses for quality;

(d) Must agree to participate in a value-based payment agreement consistent with the goals of the Value-Based Payment Compact; and

(e) Are subject to the health outcome and quality measures and benchmarks established by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638, and the Behavioral Health Committee in accordance with ORS 413.017 (5).

(9) Purchasers participating in the program select their own benefit packages and may adjust the benefit packages as desired. Benefit packages must include medical, pharmacy and behavioral health benefits but may not include dental or vision benefits, which may be purchased on the commercial market if desired.

(10) All participating payers and purchasers must agree to include in the program all of their enrollees or beneficiaries who reside in the region.

(11) All payers, purchasers and providers, except nonemployer individual purchasers of insurance, must agree to:

(a) Adhere to the health care cost growth targets established under ORS 442.386; and

(b) Not reduce access to care or reduce benefits to achieve cost savings.

(12) The authority shall:

(a) Be responsible for procurement and contracting processes.

(b) In collaboration with the Department of Consumer and Business Services, set global budgets based on per member per month rates and on quality measures that are risk-adjusted specifically for each payer's benefit packages, enrollee health status and other relevant adjustments. In areas with substantial and disproportionate numbers of high-risk or vulnerable patients, the authority shall adjust per member per month rates to account for the differing levels of need.

(c) Establish a process for payers to appeal rates.

(d) Establish a model process that payers may use to set provider rates and to risk-adjust provider rates to avoid penalizing providers that care for higher need patient populations.

(e) Except pursuant to subsection (9) of this section, ensure that costs are not excessively shifted to enrollees.

(f) Subject to subsection (14) of this section, provide regulatory relief for payers and providers and give them sufficient flexibility from state regulations to provide incentives for innovation.

(g) Offset administrative burdens, especially on providers, with the development of and state investment in a centralized infrastructure to allow for complete and transparent reporting of data that can be the foundation for expansion of the program over time.

(h) Apply equity-related performance measures and tie earning incentives to the measures.

(i) Establish a monitoring system with requirements for participant reporting.

(j) Collect data for cost and quality measures to ensure that participation in the program does not reduce access to care or benefits for individuals residing in the region.

(k) Construct a comparison group representing patients or providers that are not participating in the program to determine the program's impact.

(L) During the early stages of the program, collect and share information on a regular basis with participants on a timely basis so that participants can make improvements during the initial stages.

(13) To the extent practicable, the Public Employees' Benefit Board and the Oregon Educators Benefit Board must be assured the ability, using risk mitigation strategies or other means, to maintain their single risk pools, statewide rating approaches and their 3.4 percent cost growth targets.

(14) The authority may not provide regulatory relief under subsection (12)(f) of this section that:

(a) Impacts workforce requirements such as patient to staff ratios and staffing committees; or

(b) Is likely to endanger the health or safety of patients or providers.

(15)(a) The authority shall convene an advisory group to make recommendations to the authority regarding the health equity fund described in subsection (5) of this section. The recommendations must include a formula or process for determining payers' contributions to the fund and criteria for distributions to payers from the fund.

(b) A majority of the membership of the advisory group must consist of individuals representing:

(A) Communities of color;

(B) Tribal communities;

(C) Immigrants and refugees;

(D) Participating purchasers; and

(E) Rural, frontier or underserved areas.

SECTION 2. During the first five years of the Aligning for Health Pilot Program established in section 1 of this 2023 Act:

(1) The fixed rate of growth in the global budgets under section 1 (7)(a)(C) of this 2023 Act shall be:

(a) In the first 12-month period of the program, 2.5 percent above the health care cost growth target established in ORS 442.386.

(b) Decreased by 0.5 percent for each subsequent 12-month period of the program through the fifth year of the program.

(2) The risk mitigation strategy under section 1 (5) of this 2023 Act shall include, in addition to a health equity fund, stop-loss coverage that pays all claims for an enrollee that exceed:

(a) $100,000 in the first 12-month period of the program;

(b) $200,000 in the second 12-month period of the program;

(c) $300,000 in the third 12-month period of the program;

(d) $400,000 in the fourth 12-month period of the program; and

(e) $500,000 in the fifth 12-month period of the program.

SECTION 3. (1) The Oregon Health Authority shall adopt rules for the timing of the rollout of each phase of the Aligning for Health Pilot Program established in section 1 of this 2023 Act.

(2) The authority shall conduct an interim assessment of the program following the completion of the first phase of the program and make appropriate adjustments to the program.

(3) Upon the close of the request for proposal period, the authority shall submit to the interim committees of the Legislative Assembly, or the committees of the Legislative Assembly if the Legislative Assembly is in session, related to health a report of the responses that the authority received to the request for proposal issued for the program.

(4) Following the implementation of the third phase of the program, the authority shall complete a formal evaluation of the pilot program and report to the interim committees of the Legislative Assembly related to health, in the manner provided in ORS 192.245, the success of the program in achieving the goals described in section 1 of this 2023 Act and recommendations for continuing or expanding the pilot program in the future.

SECTION 4. Sections 1, 2 and 3 of this 2023 Act are repealed on January 2, 2034.