

Oregon Health Policy Board

AGENDA

January 24, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

8:00 am to 12:30 pm

Live web streamed at: [OHPB Live Web Streaming](#)

| # | Time | Item | Presenter | Action Item |
|----|-------|--|---|-------------|
| 1 | 8:00 | Welcome, call to order and roll call Consent agenda: 1/10/11 minutes Video: Patient talks about coordinated care | Chair | X |
| 2 | 8:05 | Director's Report | Bruce Goldberg | |
| 3 | 8:25 | Medical Liability Report | Jeanene Smith Michelle Mello (phone) Kate Baicker (on phone) Bill Wright (on phone) Allen Kachalia (on phone) | |
| 4 | 8:50 | Update on integration of Medicare and Medicaid services for individuals who are dually eligible | Susan Otter | |
| 5 | 9:00 | PEBB/OEBB | Diane Lovell | |
| 6 | 9:15 | Review of public comment | Tina Edlund | |
| 7 | 9:25 | CCO Implementation Proposal: Review <ul style="list-style-type: none"> • CCO certification <ul style="list-style-type: none"> ○ Transparency of application process ○ Recertification (OHA monitoring and oversight/accountability) • ADR | Diana Bianco | |
| | 10:15 | Break | | |
| 8 | 10:30 | CCO Implementation Proposal: Review (continued) <ul style="list-style-type: none"> • Governance: Proposed definition of financial risk • Patient rights (Medicaid/Medicare summary) • Payment methodologies that support the Triple Aim • Financial transparency • Matrix | Diana Bianco | |
| 9 | 11:30 | Review of HB 3650, Section 13 Approval of Proposal | Chair | X |
| 10 | 11:40 | Legislative Concept | Jeremy Vandehey | |
| 11 | 12:00 | Public Testimony | Chair | |
| 12 | 12:30 | Adjourn | Chair | |

Next Meeting:

February 14, 2011, Market Square Bldg. 1 to 5 pm

Oregon Health Policy Board

DRAFT Minutes

January 10, 2012

8:30am to 3:00pm

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

Item

Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Nita Werner, who joined by phone.

Tina Edlund was present from the Oregon Health Authority (OHA).

Consent Agenda:

The minutes from the December 13, 2011 meeting were unanimously approved.

Update on Medical Liability – Jeanene Smith

Jeanene Smith gave an update on the Medical Liability project. She spoke about Dr. Michelle Mello's and Dr. Allen Kachalia's policy analysis, which outlines possibilities, costs and benefits for medical liability reform in Oregon. The report explores the reform options offered by HB 3650, including, caps on noneconomic damages, medical panels, extending coverage under the Oregon Tort Claims Act, clarifying Oregon's joint-and-several liability reform statute and an administrative system for compensating harm resulting from medical malpractice. Smith also mentioned that the Defensive Medicine survey was finished at the end of December and its findings would be presented to the Board at the next meeting.

The Medical Liability Reform in Oregon Report can be found [here](#).

Recommendations for Workforce Models for New Systems of Care - Lisa Angus

Lisa Angus gave a presentation about Workforce Models for New Systems of Care that would help recruit, educate and retain healthcare workers. She said that after reviewing existing literature and recommendations from national bodies, and interviewing healthcare professionals, the key message was: "Interprofessional team-based care is the optimal model for integrated and coordinated health care." Angus spoke about individual and organizational competencies for interprofessional team care, including, communication, computer literacy, supportive workplace culture and community engagement.

The Oregon Healthcare Workforce Committee presentation can be found [here](#), starting on page 9.

Report on the Non-Traditional Health Workers Subcommittee – Carol Cheney

Carol Cheney gave a presentation about the Roles, Competencies and Training for Non-Traditional Health Workers. Cheney said the subcommittee went through several steps before offering recommendations to the Board, including, reviewing existing research, legislation, and programs; surveying more than 600 current non-traditional health workers and identifying competencies needed to fulfill the scope of work for non-traditional health workers in Oregon. The subcommittee offered recommendations on both training and certification that clarifies the role of the non-traditional health worker and supports community and cultural outreach.

The Oregon Healthcare Workforce Committee presentation can be found [here](#), starting on page 9.

Tri-County Medicaid Collaborative – George Brown

George Brown spoke about the history of the Tri-County Medicaid Collaborative, how the collaborative believes care can be transformed in its community and what challenges it faces. Brown said the goal is to create a new community organization that will help increase the quality of health care delivered, improve overall health outcomes and reduce the cost of care. He spoke about the work groups that the Collaborative has established, which include a Model of Care team, a Revenue Development and Distribution team, a Communications team and a Start-Up Development team. Brown said that the Board can assist the Collaborative with information sharing, fast tracking, governance, and finance.

The Tri-County Medicaid Collaborative Report can be found [here](#).

Financial Projections – Doug Elwell

Doug Elwell, Health Management Associates, gave a presentation on financial projections for Coordinated Care Organizations. His presentation broke down savings by population, year, and high and low savings. He said that the well-managed status reflects attainment of utilization of Milliman-defined benchmarks of optimal levels. He also mentioned other opportunities to reduce costs such as: integration of physical and Mental Health, Mental Health Preferred Drug List, Coding-related Audits, Primary Care Health Homes, administrative savings from MCO reductions.

The Health Management Associates Presentation can be found [here](#).

Review of Public Comment – Tina Edlund

Tina Edlund summarized public comment sent to the Board regarding the CCO Implementation Proposal. Edlund said the responses covered a large variety of topics, including, continuity of care, transparency, women's health, mental health, equity, fast-tracking, accountability and complimentary and alternative medicine.

The CCO Implementation Proposal Public Comment Summary can be found [here](#).

Proposal Discussion – Diana Bianco

Diana Bianco lead a discussion about the CCO Implementation Proposal that covered the following topics:

- Alternative dispute resolution
- Accountability
- Certification process
- Patient rights, responsibilities, engagement and choice
- Delivery system
- Payment methodologies
- People eligible for both Medicare and Medicaid

Topics of extensive discussion included payment methodologies that support the Triple Aim, financial transparency and accountability, and provider non-discrimination language.

The Second Draft of the CCO Implementation Proposal can be found [here](#).

Proposal Review – Diana Bianco

Diana Bianco reviewed the second draft of the CCO Implementation Proposal with the Board, page by page.

The Second Draft of the CCO Implementation Proposal can be found [here](#).

Public Testimony – Chair Eric Parsons

The board heard public testimony from seven people:

- Laura Farr, Oregon Association Of Naturopathic Physicians, spoke about the need to add language that defines primary care providers as all licensed providers working at the top of their scope. Farr said that without that language, patients could have interruptions in the quality and continuity of their care. She also said that naturopathic physicians should not be included in the complimentary and alternative medicine category because they can and do perform the same duties that general practice physicians can and do perform.
- Vern Saboe, Oregon Chiropractic Association, said Coordinated Care Organizations should not be allowed to discriminate against any health care provider practicing within their scope, licensure or certification. He said that Oregonians want to see chiropractic physicians and that alternative medicine can help curb prescription medication use. Saboe stressed that inclusive language should be included in the proposal presented to the legislature.
- Laura Ocker, Oregon Association of Acupuncture and Oriental Medicine, spoke about CCOs offering access to complimentary and alternative medicine providers. She said patients thrive when they have the opportunity to access a variety of therapies in addition to primary care; regular

access to acupuncture treatment can help people address chronic pain, acute pain, stress, depression, anxiety, insomnia and other common complaints; integrating acupuncture with primary care improves job satisfaction of medical providers; and that regular access could reduce emergency department visits associated with chronic pain and addictions issues.

- Kat Latet, Oregon Primary Care Association, said her organization would like CCOs to establish health outcome metrics that will account for patients who experience psychological and social barriers to health. Latet said that not addressing these barriers could lead to increased costs.
- Carolynn Kohout, a personal health navigator, spoke about specific language fixes she would like to change in the Proposal.
- Mike Saslow, Consumer Advisory Panel for HITOC, offered critique of the OHA and OHPB testimony presented to the legislature in December. He said providing focused testimony and more legible PowerPoint slides would help communicate the CCO model with clarity.
- Doug Riggs, health care consultant, spoke about governance and accountability. He said stakeholders want more transparency in how a CCO governing board operates. Riggs said adding a simple requirement of public board meetings would fix this problem. He also said those with broadly-defined financial risk should have a place on the governing board.

Written testimony that was handed out is available on the Policy Board meetings page:

<http://health.oregon.gov/OHA/OHPB/meetings/index.shtml>

Adjourn

Next meeting:

January 24, 2012

8:00 a.m. to 12:30 p.m.

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201

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**Monthly Report to
Oregon Health Policy Board
January 24, 2012**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

- Through December 2011, **108,148** more children have been enrolled into Healthy Kids for a total child enrollment of **378,221**.
- **6,503** of these children are now enrolled in Healthy KidsConnect.
- This is 135% of our goal of 80,000 more children and a 40% increase in enrollment since June 2009 (baseline).
- *See the attached table for a more detailed look at Healthy Kids enrollment.*

OHP Standard

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of November 15, 2011, enrollment in OHP Standard is now **66,200**.
- There have now been twenty-three random drawings to date. The last drawing was on December 7, 2011 for 6,400 names.

Charts Pack

The attached charts outline the kind of savings that can be achieved over the next 10 years through health system transformation. A review of these charts will be given during the board meeting as part of this report.

Upcoming

Next OHPB meeting:

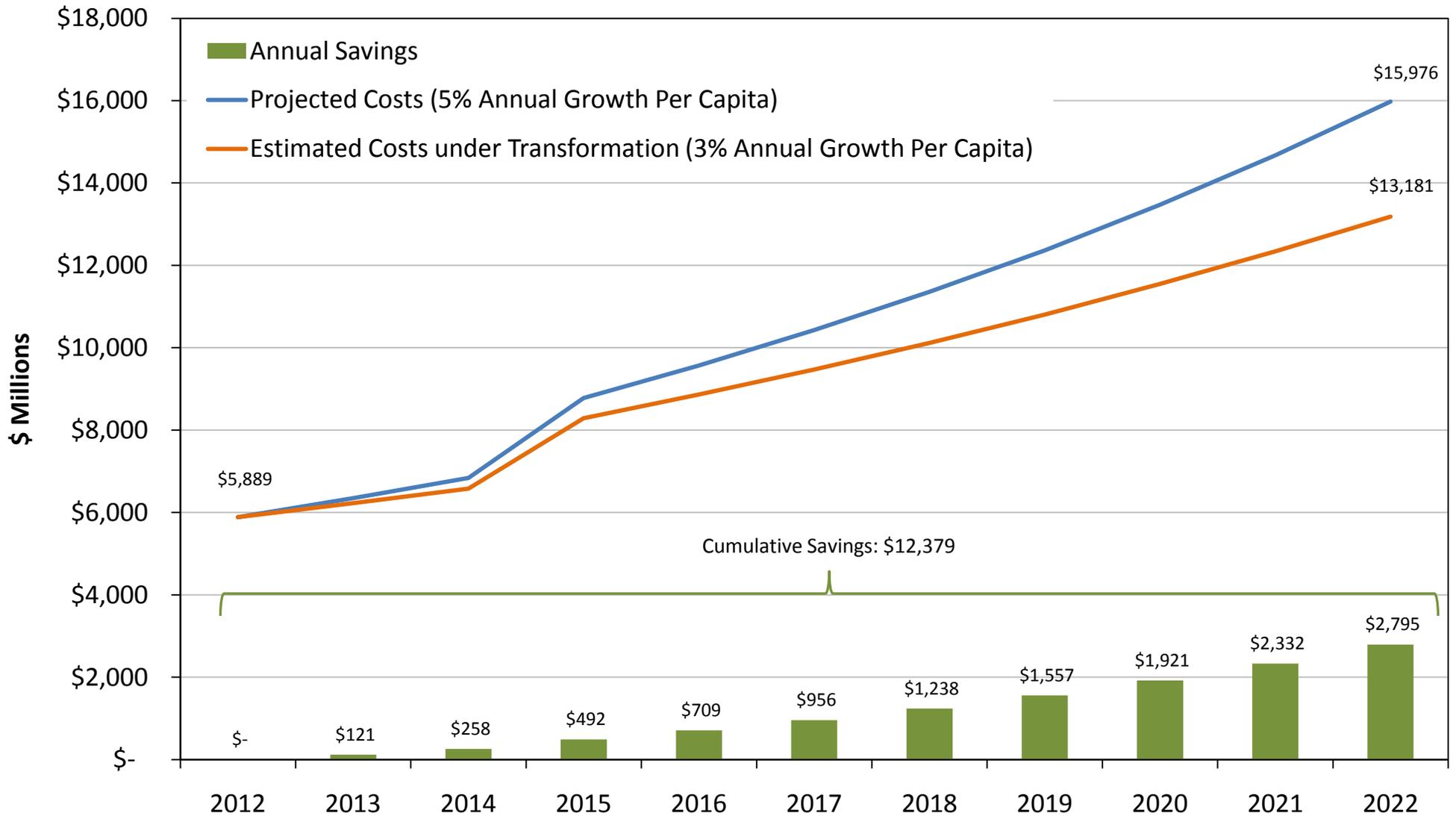
February 14, 2012

1:00 PM to 5:00 PM

Market Square Building

| | OHP Net Enrollment | HKC Net Enrollment | Total Net Enrollment | Increase Over Baseline | Monthly net enrollment change | % of Goal Achieved |
|---------|--------------------|--------------------|----------------------|------------------------|-------------------------------|--------------------|
| 9-Jul | 271,493 | 0 | 271,493 | 3,648 | 3,648 | 5% |
| 9-Aug | 276,712 | 0 | 276,712 | 8,867 | 5,219 | 11% |
| 9-Sep | 281,374 | 0 | 281,374 | 13,529 | 4,662 | 17% |
| 9-Oct | 289,015 | 0 | 289,015 | 21,170 | 7,641 | 26% |
| 9-Nov | 294,459 | 0 | 294,459 | 26,614 | 5,444 | 33% |
| 9-Dec | 298,600 | 0 | 298,600 | 30,755 | 4,141 | 38% |
| 10-Jan | 303,026 | 0 | 303,026 | 35,181 | 4,426 | 44% |
| 10-Feb | 305,785 | 205 | 305,990 | 38,145 | 2,964 | 48% |
| 10-Mar | 309,047 | 549 | 309,596 | 41,751 | 3,606 | 52% |
| 10-Apr | 312,191 | 923 | 313,114 | 45,269 | 3,518 | 57% |
| 10-May | 314,933 | 1,133 | 316,066 | 48,221 | 2,952 | 60% |
| 10-Jun | 316,891 | 1,338 | 318,229 | 50,384 | 2,163 | 63% |
| 10-Jul | 319,878 | 1,662 | 321,540 | 53,695 | 3,311 | 67% |
| 10-Aug | 322,694 | 1,948 | 324,642 | 56,797 | 3,102 | 71% |
| 10-Sep | 326,545 | 2,335 | 328,880 | 61,035 | 4,238 | 76% |
| 10-Oct | 331,837 | 2,700 | 334,537 | 66,692 | 5,657 | 83% |
| 10-Nov | 334,120 | 3,046 | 337,166 | 69,321 | 2,629 | 87% |
| 10-Dec | 337,498 | 3,441 | 340,939 | 73,094 | 3,773 | 91% |
| 11-Jan | 342,272 | 3,712 | 345,984 | 78,139 | 5,045 | 98% |
| 11-Feb | 348,660 | 4,081 | 352,741 | 84,896 | 6,757 | 106% |
| 11-Mar | 349,424 | 4,372 | 353,796 | 85,867 | 971 | 107% |
| 11-Apr | 353,526 | 4,732 | 358,258 | 90,329 | 4,462 | 113% |
| 11-May | 354,070 | 4,970 | 359,040 | 91,111 | 782 | 114% |
| 11-June | 356,645 | 5,196 | 361,841 | 93,892 | 2,781 | 117% |
| 11-July | 358,990 | 5,419 | 364,409 | 96,432 | 2,540 | 121% |
| 11-Aug | 360,644 | 5,626 | 366,270 | 98,300 | 1,868 | 123% |
| 11-Sep | 363,474 | 5,935 | 369,409 | 101,428 | 3,128 | 127% |
| 11-Oct | 366,811 | 6,140 | 372,951 | 104,890 | 3,462 | 131% |
| 11-Nov | 367,953 | 6,364 | 374,317 | 106,241 | 1,351 | 133% |
| 11-Dec | 369,723 | 6,503 | 376,226 | 108,148 | 1,907 | 135% |

Oregon's Medicaid Program Savings Could Exceed \$12 Billion over 10 Years (Total Funds)



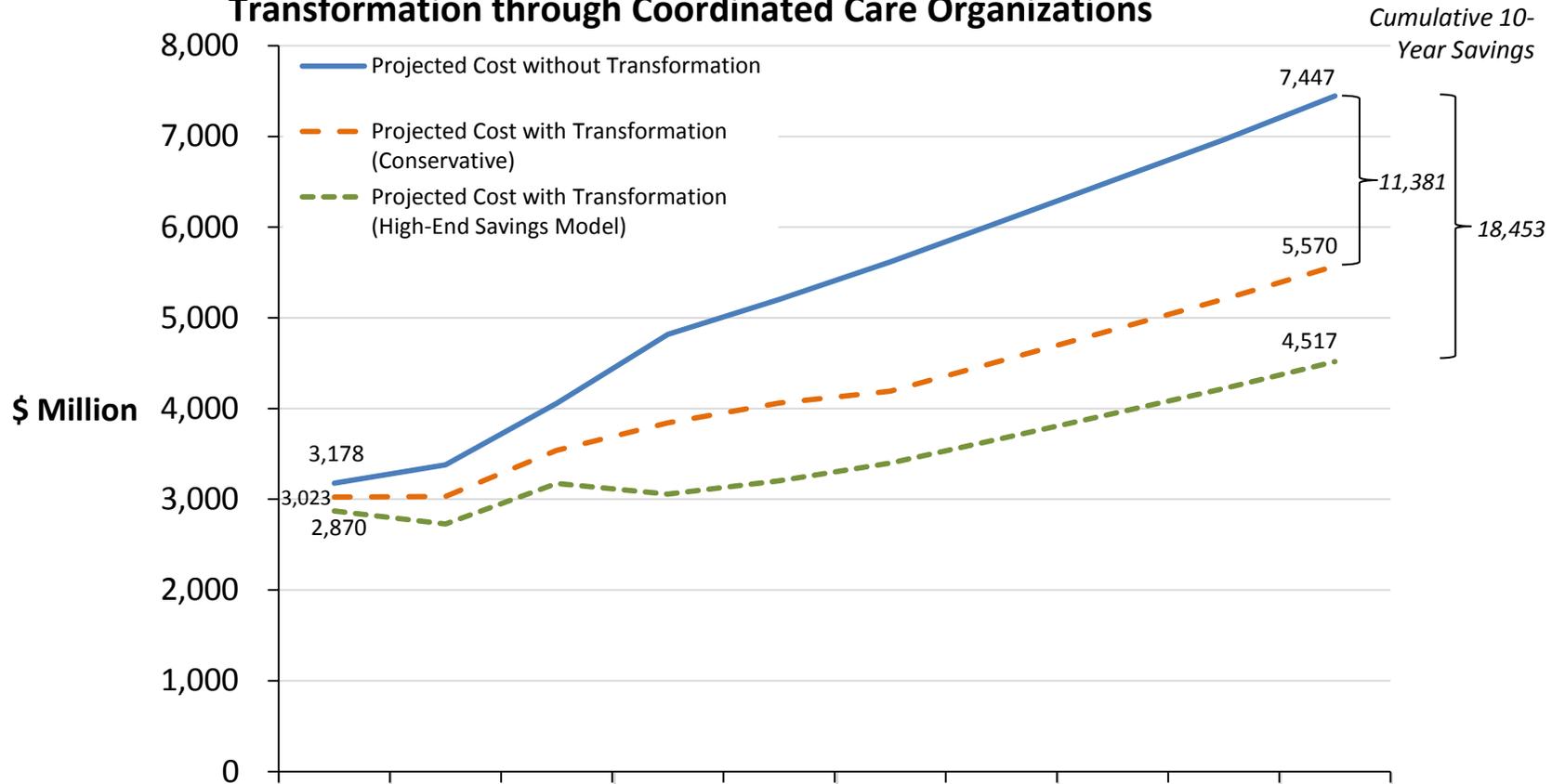
Source: Total Medicaid spending for Oregon from Kaiser State Health Facts, 2011. Cost growth rate for Medicaid for Oregon, 2004-2009, from CMS Center for Strategic Planning, Medicare and Medicaid Research Review, Health Spending by State of Residence 1991-2009, 2011. Enrollment growth from 2013-2022 based on OHA forecasting estimates through 2014. ACA Medicaid expansion enrollment from Gruber Microsimulation Model.



Notes: Estimates include Medicaid total funds expenditures.

January 9, 2012

Health Management Associates' Annual Projected Savings Attributable to Health System Transformation through Coordinated Care Organizations



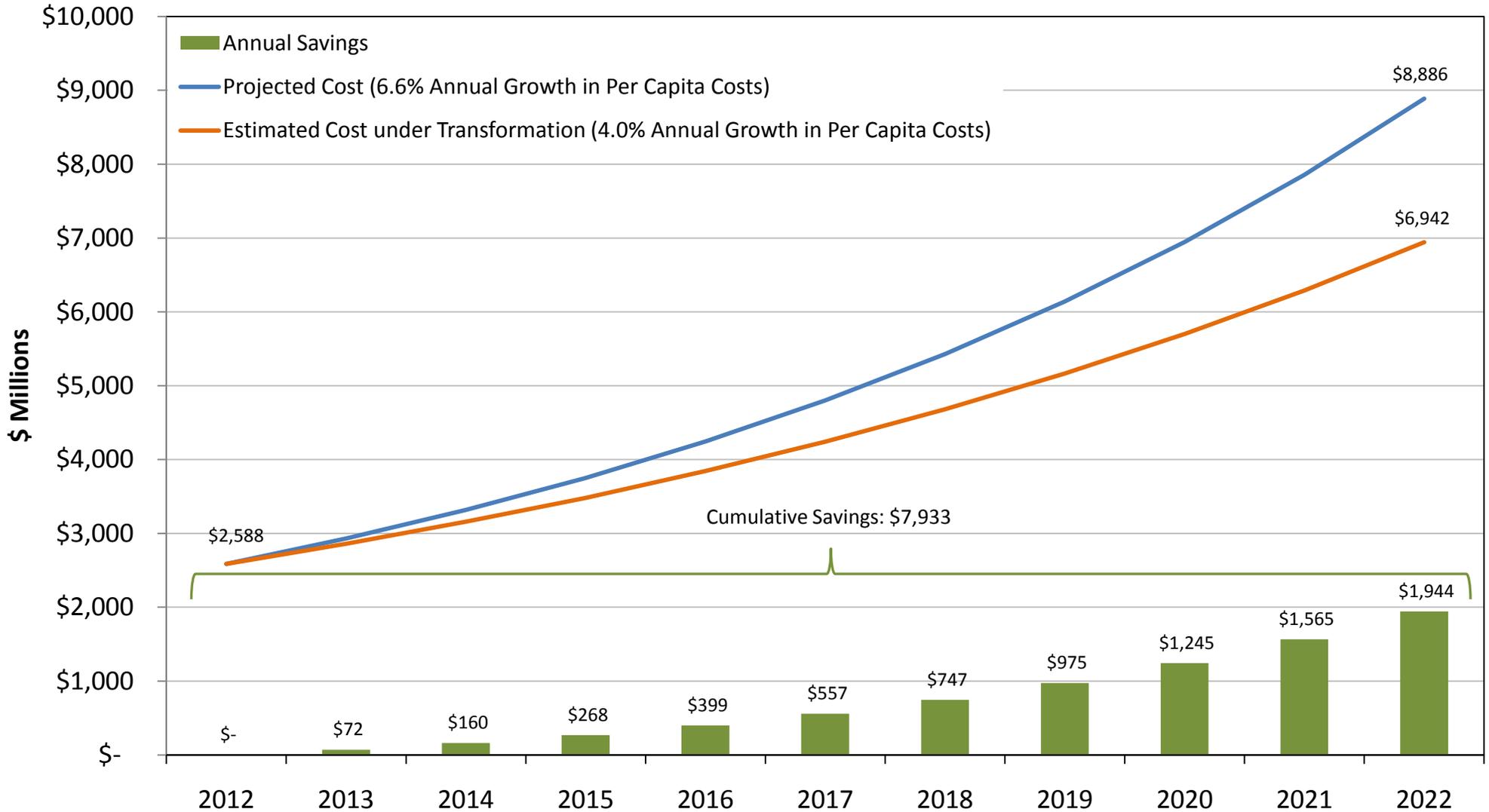
| | 12-13 | 13-14 | 14-15 | 15-16 | 16-17 | 17-18 | 18-19 | 19-20 | 20-21 | 21-22 |
|---------------------------------------|-------|-------|--------|--------|--------|-------|-------|-------|-------|-------|
| Costs w/o Transformation | 3,178 | 7,440 | 10,019 | 11,680 | 13,474 | 7,447 | | | | |
| Costs w Transformation (Conservative) | 3,023 | 6,571 | 7,904 | 8,720 | 10,069 | 5,570 | | | | |
| Costs w Transformation (High Savings) | 2,870 | 5,903 | 6,260 | 7,068 | 8,165 | 4,517 | | | | |
| Annual Savings (Conservative) | 155 | 869 | 2,115 | 2,961 | 3,405 | 1,877 | | | | |
| Annual Savings (High-End) | 308 | 1,536 | 3,759 | 4,612 | 5,309 | 2,929 | | | | |

Source: Health Management Associates

Notes: Health Management Associates' projections end in 2019. The 2019-2021 biennium and 2021-2022 state fiscal year were extended forward by the Oregon Health Authority by applying the growth rates in HMA's model.



Oregon's Medicare Program Savings for Dually Eligible Individuals Could Reach \$8 Billion over 10 Years



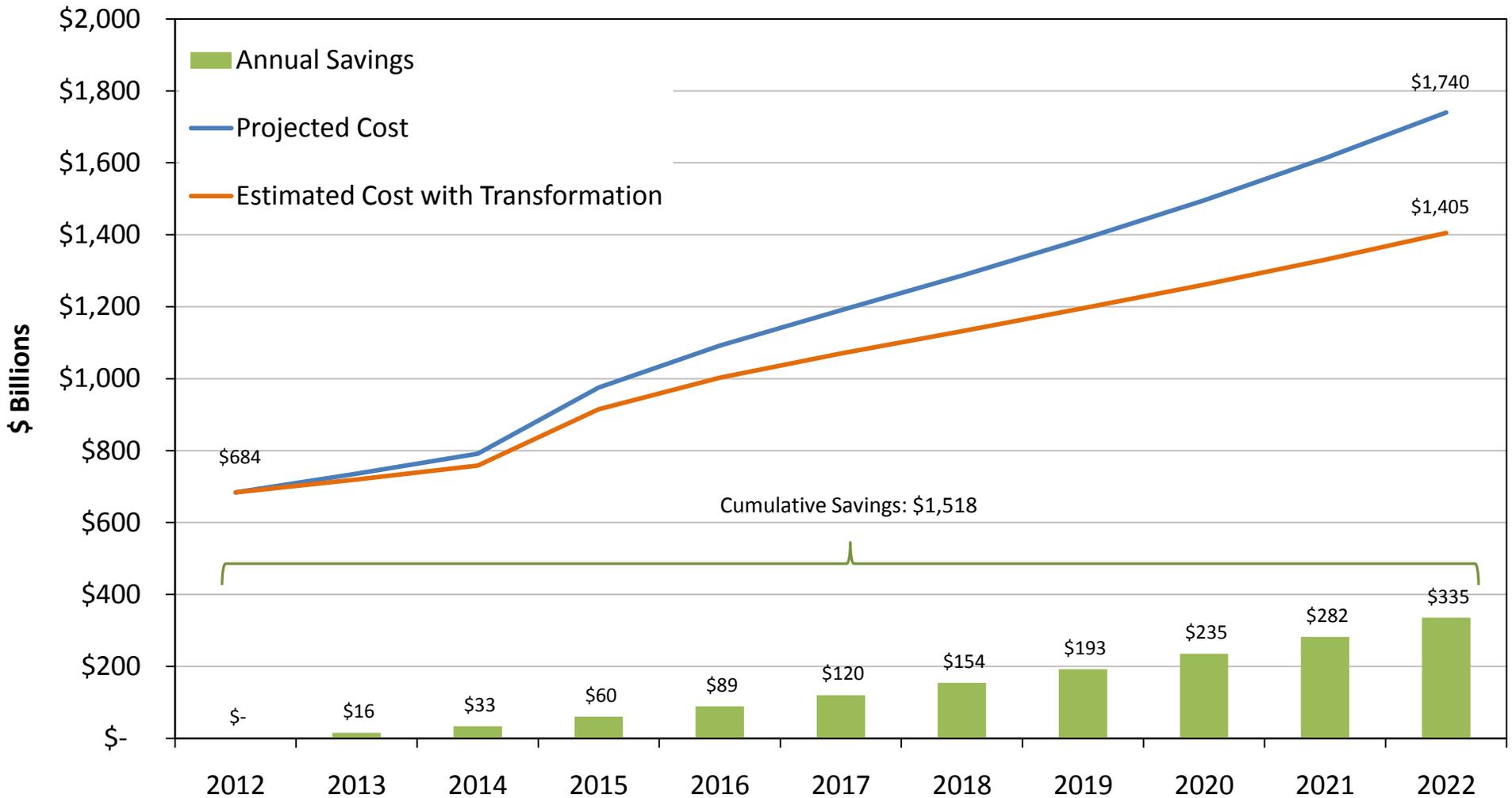
Source: Total Medicare spending for Oregon from Kaiser State Health Facts, 2011. Cost growth rate for Medicare for Oregon, 2004-2009, from CMS Center for Strategic Planning, Medicare and Medicaid Research Review, Health Spending by State of Residence 1991-2009, 2011. Enrollment growth from 2013-2022 based on OHA forecasting estimates.

Notes: Estimates include Medicare expenditures for dual eligible enrollees only, which are estimated at 36% of total Medicare expenditures.



January 9, 2012

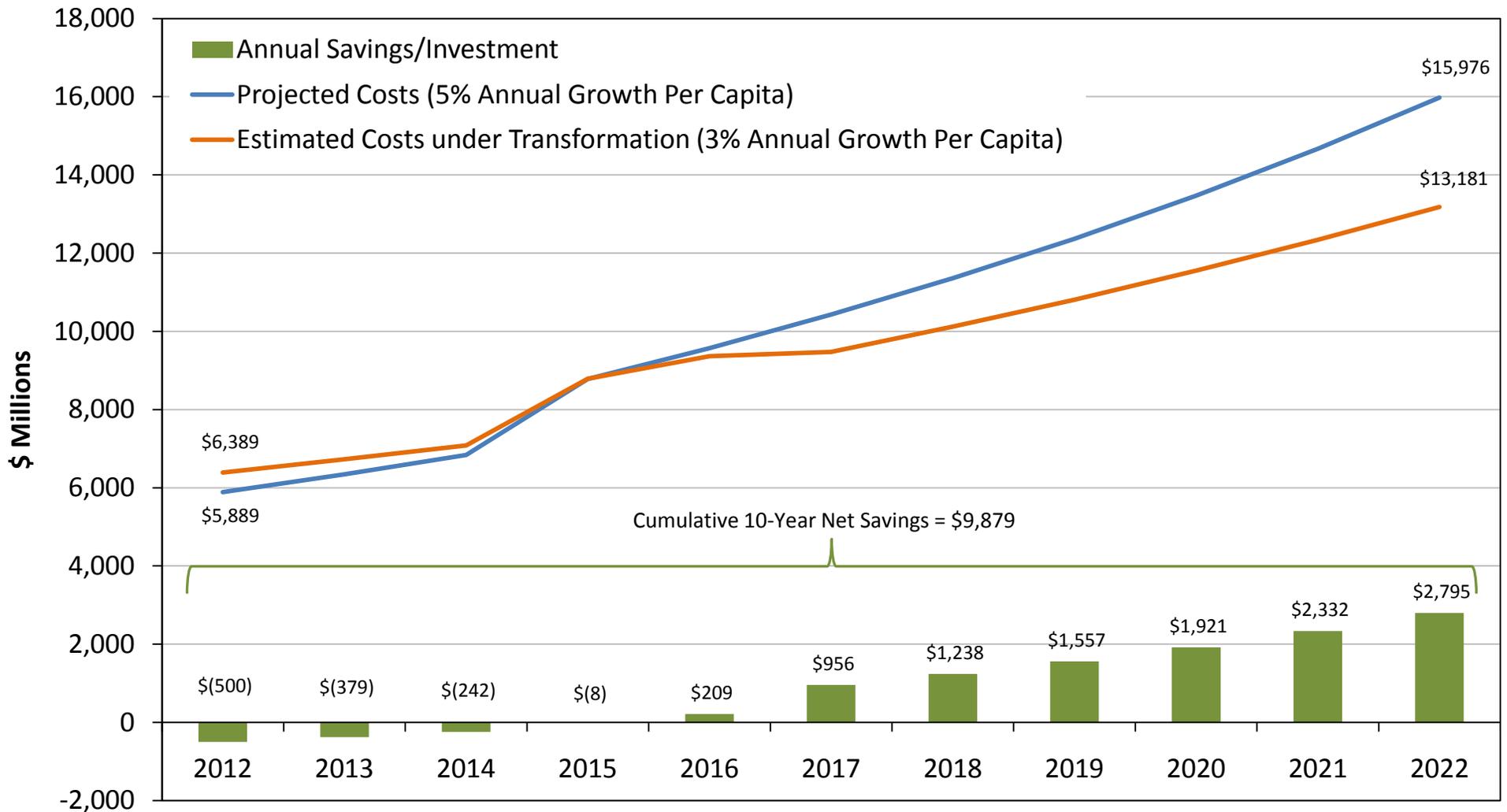
The U.S. Could Save Over \$1.5 Trillion Over 10 Years Through Medicaid Transformation and Improved Coordination for Dual Eligibles (Total Funds)



Sources: Total Medicaid and Medicare spending from Kaiser State Health Facts, 2011. Cost growth rate for Medicaid and Medicare, 2004-2009, from CMS Center for Strategic Planning, Medicare and Medicaid Research Review, Health Spending by State of Residence 1991-2009, 2011. Medicaid and Medicare enrollment growth by state of residence, National Health Expenditure Data, 2009. ACA Medicaid expansion enrollment from John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform," May 2010.

Notes: Estimates include all Medicaid expenditures for all U.S. states and D.C. as well as Medicare expenditures for dual eligibles. Annual savings estimates assume a two percentage point decrease in Medicaid per capita cost growth and a 2.6 percentage point decrease in Medicare per capita cost growth for Medicare expenditures for dual eligibles. Dual eligible expenditures assumed to be 36% of total Medicare spending.

Oregon's Medicaid Program Net Savings Could Reach \$10 Billion over 10 Years (Total Funds)



Source: Total Medicaid spending for Oregon from Kaiser State Health Facts, 2011. Cost growth rate for Medicaid for Oregon, 2004-2009, from CMS Center for Strategic Planning, Medicare and Medicaid Research Review, Health Spending by State of Residence 1991-2009, 2011. Enrollment growth from 2013-2022 based on OHA forecasting estimates through 2014. ACA Medicaid expansion enrollment from Gruber Microsimulation Model.



Notes: Estimates include Medicaid total funds expenditures.

January 9, 2012

The Oregon Defensive Medicine Study

Policy Brief

OVERVIEW

This brief summarizes results from a study of defensive medicine in Oregon commissioned by the Oregon Health Authority (OHA), pursuant to a legislative mandate in Section 16 of House Bill 3650 (2011), also known as the Health Care Transformation bill. The study's purpose was to estimate the costs of defensive medicine in Oregon, and to estimate the prevalence and costs associated with overutilization and unnecessary care. Two independent researchers -- Bill J Wright, PhD from the *Center for Outcomes Research & Education* at Providence Health & Services and Katherine Baicker, PhD from the *Harvard School of Public Health* -- conducted the study.

APPROACH

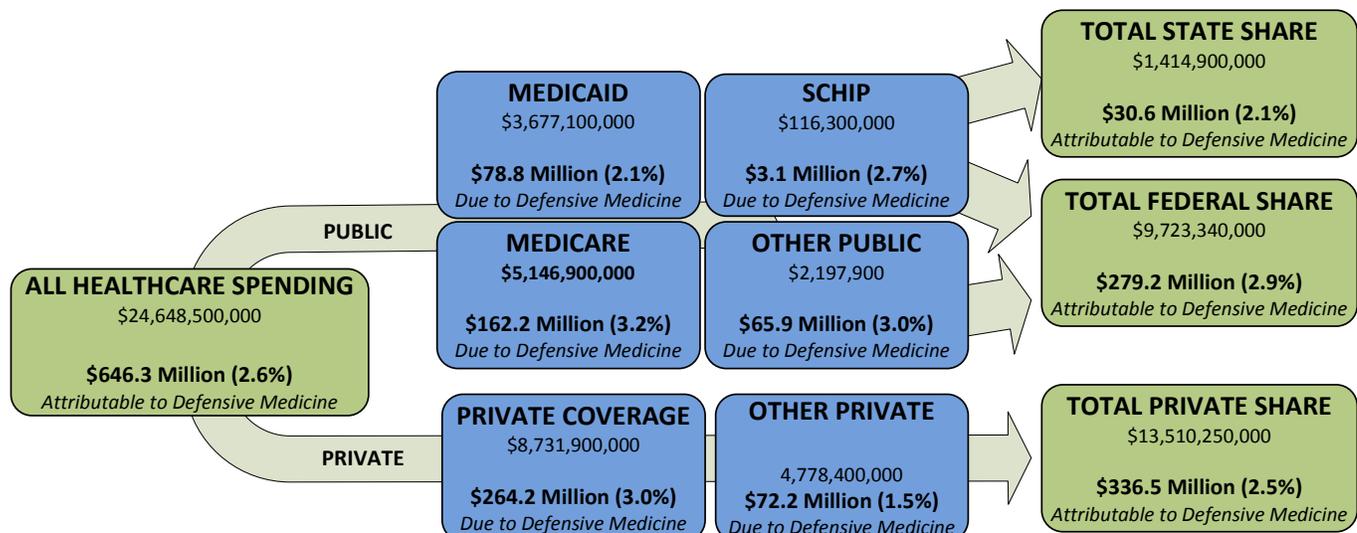
Two distinct approaches were taken to meet the project's objectives.

- **MEDICAL EXPENDITURES DATA:** To estimate total defensive medicine costs, we took the best estimates from the health economics literature about how much of different types of healthcare spending might be attributable to defensive medicine and applied them to Oregon healthcare expenditures data.
- **PHYSICIAN SURVEYS:** We fielded a statewide survey of 2,600 actively practicing physicians in Oregon. We used survey results to produce estimates on the prevalence of unnecessary care within different types of healthcare services, then generated estimates of the cost associated with each type of care.

KEY FINDING #1: COSTS OF DEFENSIVE MEDICINE IN OREGON

Our analysis of Oregon health expenditures data suggests that annually, approximately **\$650 million** in healthcare spending – or about 2.6% of total healthcare spending in Oregon – may be attributable to defensive medicine. Just under half (\$310 million) is through public programs, with most of that accounted for by Federal spending through Medicare and the Federal share of CHIP and Medicaid. The direct impact on Oregon's budget is about **\$31 million**.

ESTIMATED COSTS OF DEFENSIVE MEDICINE IN OREGON



BOTTOM LINE: Defensive medicine costs are about \$646 Million across the entire Oregon economy. Direct costs to the Oregon budget are about \$30 million.

LIKELY IMPACTS OF REFORM: We also estimated the potential savings to Oregon's budget of "direct reform" options, such as caps on non-economic damages. We estimate that such reforms might save the Oregon budget about **\$20 million**.

KEY FINDING #2: PREVALENCE & COST DRIVERS OF DEFENSIVE MEDICINE

Our analysis of the prevalence of defensive medicine in Oregon relied on a survey of 2,600 active Oregon physicians. We used a “count based” approach to assessing prevalence – physicians were given a list of procedures often associated with defensive practice and asked to count how many had they ordered in their last full month of work, then estimate how many of the orders were for medically unnecessary care. We used those results to estimate the total annual number of “unnecessary” orders for each type of care, and then multiplied the result by the average cost of each procedure to estimate the total costs associated with each type of overutilization. We combined similar procedures into broad categories and produced the following overutilization estimates:

| Type of Service | Overutilization Rate | Associated Costs | Percent of Associated Costs |
|--|----------------------|------------------|-----------------------------|
| Imaging (X-Rays, CT scans, MRI, Ultrasounds) | 16.2% | \$141.0 M | 19% |
| Laboratory Tests (CBC, Chem profile, etc) | 13.9% | \$24.5 M | 3% |
| Specialist referrals or consults | 17.2% | \$27.3 M | 4% |
| Hospital admissions | 8.2% | \$552.7 M | 74% |
| TOTAL OVERUTILIZATION & COSTS | 13.9% | \$745.6 M | 100% |

The total cost estimates we produced using our survey data differed slightly from our estimates based on health expenditures data (\$745 million vs. 646 million). The two approaches are not directly comparable because they use fundamentally different methodologies; however, they actually yield quite complementary results: as a percentage of total healthcare spending, the estimates fall within less than .05% of each other (2.6% vs. 3.0% of total spending).

ASSESSING THE SUBJECTIVITY OF DATA

Our analysis of the total costs of defensive medicine used objective data on Oregon healthcare expenditures. However, we used surveys to produce our overutilization estimates, and survey responses can be notoriously subjective depending on the context within which questions are asked. We wanted to ensure our estimates of overutilization were as scientifically valid as possible, so we embedded an experimental design into our assessment of overutilization rates in Oregon. This experiment, described in our report, allowed us to essentially assess the degree of subjectivity present in the estimates of overutilization drawn from our survey results. We ultimately found that our approach yielded highly reliable results.

KEY TAKEAWAYS

Our surveys of Oregon physicians suggest that, within the most common categories of care usually associated with defensive practice, as many as **14% of physician orders may be medically unnecessary**. Our analysis of expenditures data suggests that an estimated **\$650 million** in total costs of care may be attributable to defensive medicine statewide, though most of these costs flow through private insurers or federal payments; the Oregon state budget’s share is about **\$31 million**. Both analyses agree that **unnecessary care in hospital settings** is the most important driver of defensive medicine costs, accounting for 74% of costs associated with overutilization.

The costs of defensive medicine should not be seen as entirely “recapturable.” Not all unnecessary care can be attributed to the malpractice environment, and no known malpractice reform scenario would reduce defensive medicine to zero. Applying the best available estimates on the likely savings of direct malpractice reforms (such as damage caps) to Oregon expenditures data suggests that such reforms might reduce total healthcare expenditures by **\$345 million** across the entire Oregon economy. However, most of that reduction would fall under federal or private expenditures – **direct savings to Oregon’s budget would be an estimated \$20 million**.

CONTACT

Please contact Bill Wright, PhD with questions about this study (bill.wright@providence.org; 503-215-7184).

HB 3650 Section 16: Update on Medical Liability Studies

January 2012

Oregon
Health
Authority

OREGON HEALTH POLICY & RESEARCH

Section 16 Requirements

Section 16 of the Transformation Bill (HB 3650, 2011) requires that the Oregon Health Authority (OHA) conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice.

Specific Requirements

Specifically, Section 16 directs OHA to explore the costs, benefits and impacts of defensive medicine and several types of medical liability reform options:

- Legislative and administrative remedies
- Caps on damages
- Medical panels
- Extension of the Tort Claims Act to Medicaid
- Joint and several liability options

Four Components of Work

- **Defensive medicine and overutilization studies** – Studying the practice of defensive medicine in Oregon health care and potential savings from reducing the practice.
- **Medical liability policy analysis** – Assessing the benefits and potential impacts of liability reform options and applicability to the Oregon marketplace.
- **Legal analysis** – Exploring the legal and constitutional issues of different medical liability reform options in Oregon.
- **Stakeholder input** – Soliciting stakeholder groups for the best sources of information and research on medical liability reform options in the Oregon marketplace.

Consultants, Internal Experts, Stakeholders

The OHA procured expert consultants, worked with internal experts, and solicited input from several stakeholder groups:

- **Bill Wright, Ph.D., at Providence Center for Outcomes Research and Kate Baicker, Ph.D., from the Harvard School of Public Health** completed the studies on defensive medicine and overutilization, which included a survey of Oregon medical providers addressing the practice of defensive medicine and an analysis of Oregon medical claims.
- **Allen Kachalia, M.D., J.D., and Michelle Mello, J.D., Ph.D., from the Harvard School of Public Health** completed the policy studies that included a thorough literature review and case studies while incorporating Oregon-specific analyses where available to outline the benefits and impacts of reform options.
- **The Oregon Department of Justice** completed a legal analysis of reform options in the Oregon Marketplace to identify any constitutional limitations and to clarify stark laws and their possible affect on CCOs.
- **The Oregon Health Authority** solicited input from several Oregon stakeholder organizations on information and ideas for reform options.

Medical Liability Policy Analysis

*Allen Kachalia, M.D., J.D., and Michelle Mello, J.D., Ph.D.,
Harvard School of Public Health*

- **Deliverable**

Identify the benefits, costs, and impacts of potential reform options

1. Caps on noneconomic damages
2. Medical panels (aka pre-trial screening panels)
3. Limited Oregon Tort Claims Act (OTCA) coverage extension
4. Joint-and-several liability (JSL) reform law expansion
5. Administrative compensation system

- **Approach**

- Critically reviewed and synthesized existing empirical studies
- Where possible, modeled effects in Oregon using (1) study findings about effect sizes and (2) data on Oregon malpractice claims, insurance premiums, and health care
- Considered issues/evidence from stakeholder input

Key Findings: Medical Liability Policy Analysis

- Noneconomic damages caps may bring cost savings, but likely modest, and carry risk of exacerbating inequities in awards.
- Evidence on medical panels indicates likely no tangible liability benefits and may increase litigation costs or lengthen resolution.
- OTCA extension to providers of Medicaid CCO patients likely of little liability benefit because of small number of patients and how insurance is priced. Also, likely additional cost to the state to implement and fund OTCA extension.
- JSL reform to aid CCOs offers little benefits because most providers carry insurance and settlements are almost always under policy limits; will not address claim reporting concerns for providers.
- ACS offers the greatest prospect for transformative change - but with political and legal challenges.

Defensive Medicine/Overutilization

Bill Wright, Ph.D., Providence Center for Outcomes Research

Kate Baicker, Ph.D., Harvard School of Public Health

- **Deliverable**

Use Oregon-specific data to estimate frequency and costs of defensive medicine in Oregon with identification of cost drivers.

- **Study Methodology**

- Analysis of Oregon health care expenditures data.

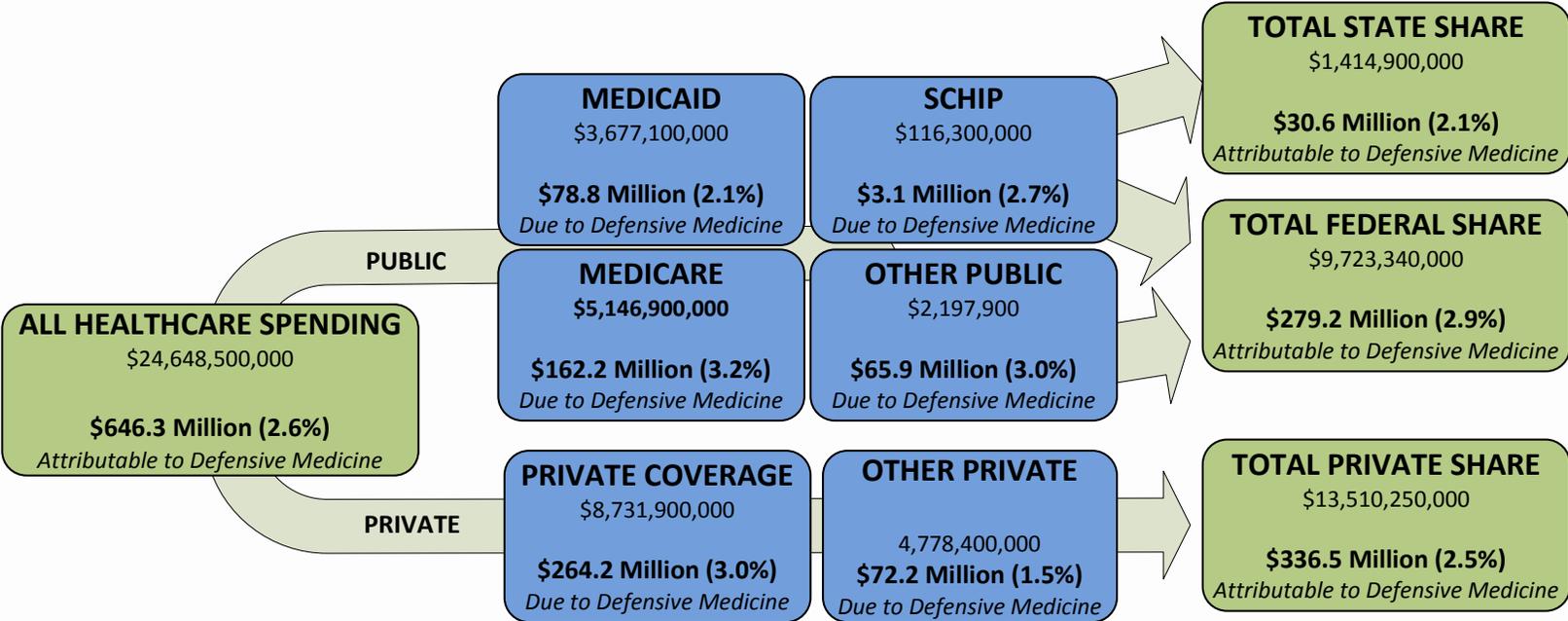
- Surveys to Oregon medical providers to determine how often they order tests or care that are not clinically indicated. To generate scientifically valid estimates and assess survey framing effects, two surveys were used:

- Some physicians received a survey on “defensive medicine.”
- Others received identical questions, but on a “cost containment” survey.

Defensive Medicine/Overutilization, *Cont...*

ANALYSIS OF HEALTHCARE EXPENDITURES DATA

Key Finding #1: Approx \$650 million in total OR healthcare spending may be attributable of defensive medicine (2.6% of total expenditures). Most is private or federal spending; the direct impact on Oregon’s budget is about \$30 million.

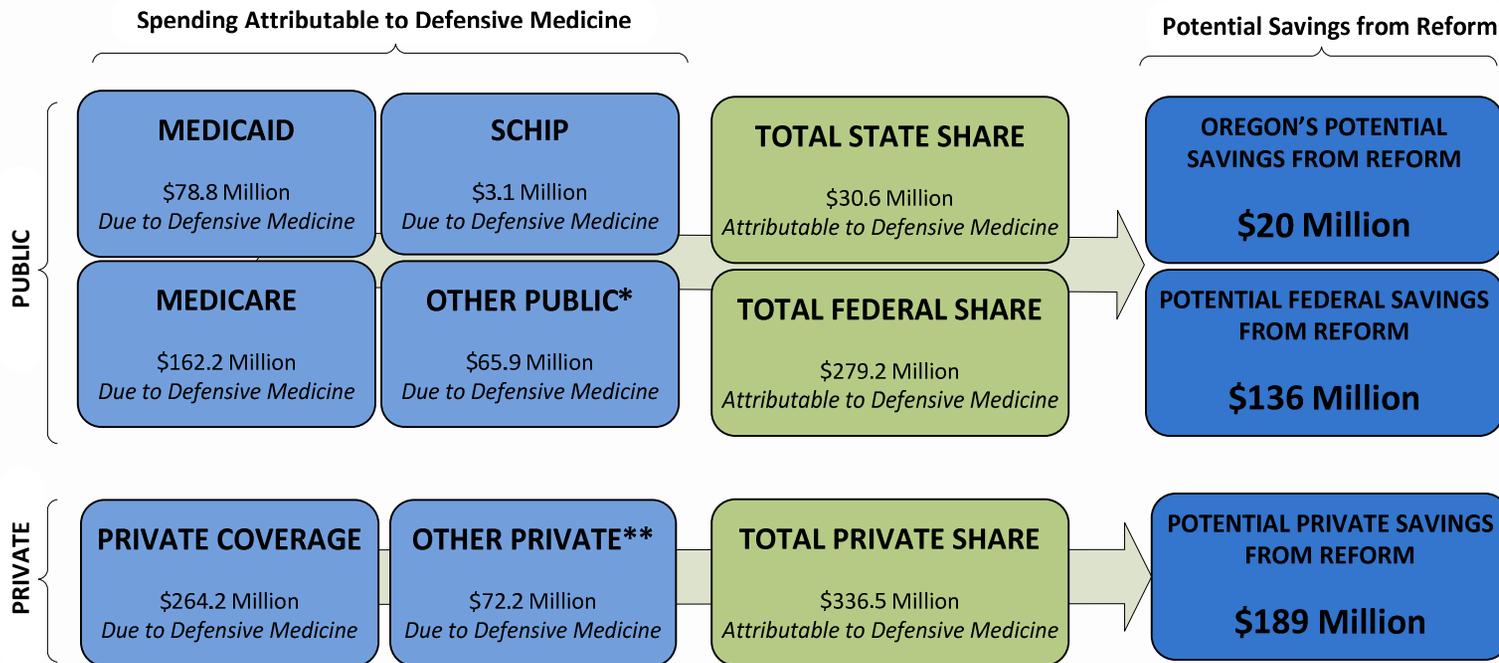


BOTTOM LINE: Defensive medicine costs are about \$646 Million across the entire Oregon economy. Direct costs to the Oregon budget are about \$30 million.

Defensive Medicine/Overutilization, *Cont...*

ANALYSIS OF HEALTHCARE EXPENDITURES DATA

Key Finding #2: The best available estimates on the potential savings of reforms suggest that direct reforms (damage caps) might reduce total OR health expenditures by 1.4%. This would translate into savings of about \$20 million in the Oregon budget.



Defensive Medicine/Overutilization, *Cont...*

ANALYSIS OF PHYSICIAN SURVEY DATA

Key Finding #3: Physician surveys suggest that 14% of the care in four key service types is “medically unnecessary.” Unnecessary hospital care accounts for the bulk of costs associated with overutilization.

| Type of Service | Overutilization Rate | Associated Costs | Percent of Associated Costs |
|--|----------------------|------------------|-----------------------------|
| Imaging (X-Rays, CT scans, MRI, Ultrasounds) | 16.2% | \$141.0 M | 19% |
| Laboratory Tests (CBC, Chem profile, etc) | 13.9% | \$24.5 M | 3% |
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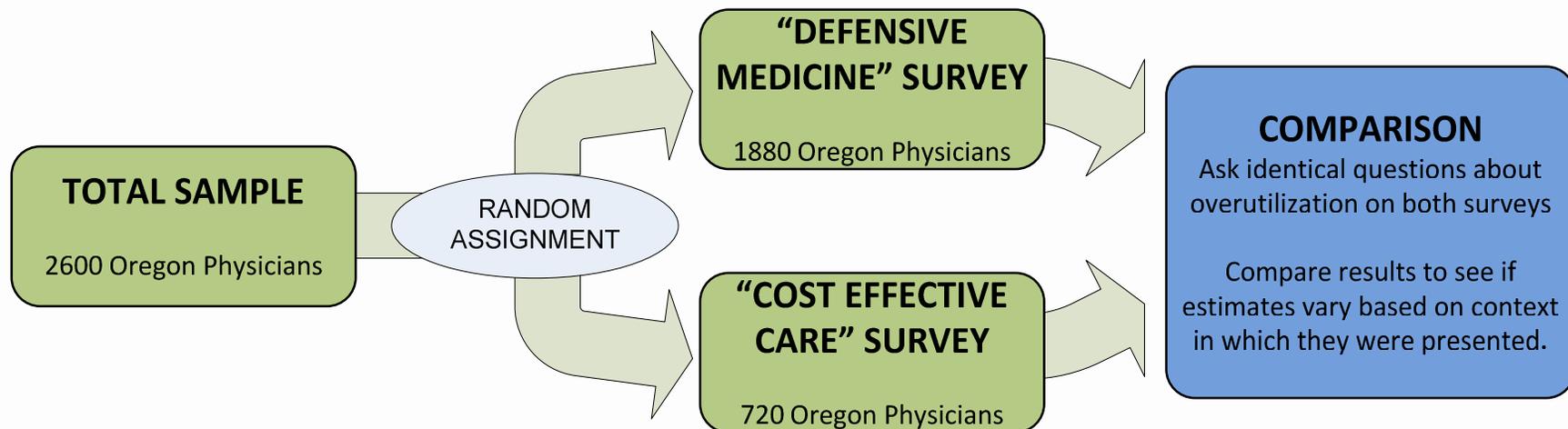
Survey estimate: \$745 M in expenditures from unnecessary care (3% of all spending).

Claims data estimate: \$646 M from defensive medicine (2.6% of all spending).

Defensive Medicine/Overutilization, *Cont...*

ANALYSIS OF PHYSICIAN SURVEY DATA

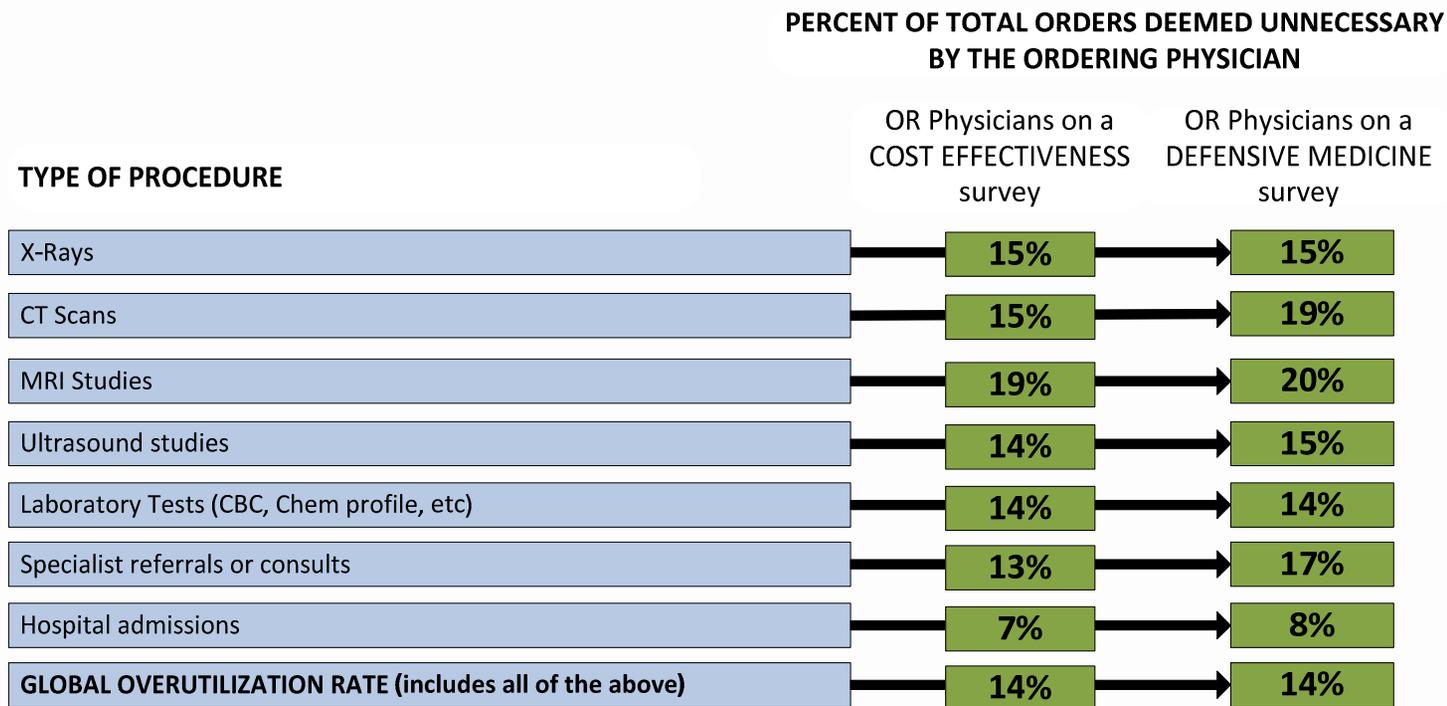
Subjectivity in survey estimates of defensive practice is a real risk. An experimental approach was used to assess the reliability of our survey estimates.



Defensive Medicine/Overutilization, *Cont...*

ANALYSIS OF PHYSICIAN SURVEY DATA

Key Finding #4: Results of our experimental approach suggest that our approach to estimating overutilization provided scientifically reliable data.



★ Differences in results were not statistically significant ($p < .05$, two-tailed chi-square tests)

Legal Analysis Under Oregon Law

Prepared by the Oregon Department of Justice (DOJ)

- **Deliverable**

Complete a legal analysis of reform options in the Oregon Marketplace to identify any constitutional limitations and to clarify Stark laws and their possible affect on CCOs.

- **Study Methodology**

- Worked with the OHA and consultants to coordinate the need for specific legal analyses for each medical liability reform option referred to in Section 16 of HB 3650.
- Completed an in-depth review of relevant case law on reform options.
- Completed a legal analysis on Stark laws and other financial interest laws.

Key Findings from Dept. of Justice Analyses:

Stark Law and Related Limitations on Financial Interests

Stark laws and related financial interest laws can impose legal constraints on some health care arrangements, but help reduce costs.

- Stark law prohibits providers from making referrals for health care services to entities in which the provider has a financial relationship; exemptions exist.
- Anti-kickback laws prohibit payments for referrals; exemptions similar to Stark.
- False claims law imposes civil liability for false or fraudulent claims which can be supported by Stark law violations.

Legal Analysis of Medical Liability Reform Options

- Extension of the Oregon Tort Claims Act must be funded or made conditional.
- Caps on damages would require a change to Oregon's constitution.
- CCOs potentially held vicariously liable for the actions of apparent agents.
- Mandatory and binding medical panels violate Oregon's jury trial provision.
- Administrative Compensation Systems do not violate Oregon's jury trial provision and should survive a challenge that they are *facially* invalid under Oregon's remedy clause.

Oregon
Health
Authority

Health System Transformation and Individuals who are Dually Eligible Update to Oregon Health Policy Board, January 24, 2012

Susan Otter, Project Director, CMS Design Contract

Susan.otter@state.or.us, 503-373-2176

Update on Duals Design Contract and 3-way Contract Opportunity:

- CMS has offered states the opportunity for 3-way contracts between health plans, state and CMS for blending Medicare and Medicaid funding for dual eligible beneficiaries
- CMS is releasing its plan requirements detailing expectations for plans under the 3-way contracts, and will be working with each state to make changes to adapt to the specific context of that state
 - o Oregon staff will work with CMS to ensure “fit” for Oregon
 - o MOU between CMS and Oregon to set terms of 3-way contracts
 - o CMS would work with OHA to certify plans (CCOs) and participate in contracting with CCOs specifically for the Medicare funding for members who are dually eligible
 - o CMS and OHA will negotiate alignment of Medicare/Medicaid requirements
- Oregon has 10 health plans that have Medicare Advantage contracts under which they coordinate care for individuals who are dually eligible (7 are “Special Needs Plans” specific to individuals who are dually eligible)
 - o Medicare demonstration would include changes to managed Medicare care to align Medicaid and Medicare requirements, and to be consistent with CMS direction for integrating care
- Duals proposal to CMS is also an opportunity to develop pilots that would test promising approaches for providing services to individuals in congregate settings, such as services to individuals residing in Section 8 housing or via new flexibilities for the Program for All-Inclusive Care for the Elderly (PACE)

CCO/LTC Coordination and Shared Accountability:

- CCO global budgets include the full Medicare benefit (and associated Medicaid cost sharing)
 - o Including Skilled Nursing Facility, home health, etc. to cover health needs
 - o Medicare Advantage plans currently have the full Medicare benefit, but not the Medicaid cost sharing
- HB 3650 excludes Medicaid-funded LTC Services and Supports
 - o Including the supports and services to assist individuals with activities of daily living provided in nursing facilities; community based care such as residential care facilities, adult foster homes, assisted living facilities; or in-home
 - o DHS will continue to pay for these services and supports directly
- Exclusion includes risk of driving up costs without coordination and accountability
 - o Opportunity for alignment, transparency, bringing costs down
- Strategies included in CCO Proposal:
 - o Requirements for coordination

- Metrics
- Contract or MOU between CCO and LTC local office
- Shared financial incentive/penalty
- CCO community needs assessments would consider LTC

Stakeholder Outreach

- Medicare-Medicaid Integration External workgroup (Aug-Nov)
- Budget Note subgroup (Oct-Dec)
- Beneficiary listening sessions (Dec)
- Ad hoc meetings with stakeholders (ongoing)

Next Steps:

- January-February: Work with CMS to ensure “fit” for Oregon
- Early February: Provide forum for interested entities to learn more about CMS requirements for plans to participate in 3-way contracts
- February: Request input from Oregon Health Policy Board
- February: Finalize Draft Proposal to Integrate Care for Dually Eligible
- March: 30-day Public Comment Period
- April: Submit revised Proposal to Integrate Care for Dually Eligible to CMS
- May/June: Develop MOU between CMS/OHA

PEBB/OEBB Plan for Transformation

Introduction

Health care costs are increasingly unaffordable—to employers and individuals, as well as federal and state governments. Growth in health care expenditures far outpaces growth in general fund revenue without a correlating improvement in health outcomes.

In 2011 the Oregon Legislature and Governor John Kitzhaber created Coordinated Care Organizations (CCOs) in House Bill 3650 aimed at achieving the triple aim of improving health, improving quality of care and lowering costs by transforming the delivery of health care under the Oregon Health Plan. The legislation¹ builds on the work of the Oregon Health Policy Board (OHPB) since 2009.

The Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) uphold a vision tightly aligned with HB 3650's objectives for health system transformation. Statutes authorizing PEBB and OEBB list key attributes for purchasing decisions that further this vision. These key attributes are:

- improvement of employee health ;
- creativity and innovation;
- plan performance and information;
- flexibility in plan design and contracting, and
- choice among high quality plans.

Guided by these key attributes, the Benefit Boards have moved forward toward their shared goal of purchasing quality plans of health benefits that are affordable for the employer and the employee. Their efforts align programs and plan designs for the following elements in House Bill 3650.

Patient Centered Primary Care Homes (PCPCH)

Today, OEBB members can select among four medical home options, and 21 percent of OEBB members are in PCPCH plans. PEBB members have a choice between two medical home options, and 34 percent (2012) of these members are in PCPCH plans.

Development of PCPCH and growth of this system of care is an ongoing collaboration among the Boards and their carrier partners. Contracts require payments for PCPCH

¹ (2) Using a meaningful public process, the Oregon Health Authority shall develop:
...(e) Plans for contracts with coordinated care organizations for other public health benefit purchasers, including the private health option under ORS 414.826, the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

certification. Goals are both to expand availability of PCPCHs geographically and to increase membership in these systems of care. The Boards review the latest PCPCH standards and adopt those that align with PEBB and OEBC needs and vision.

Quality Metrics and Accountability

Metrics and accountability are critical drivers in health care quality improvements. Metrics have enabled the Benefit Boards to track improvements in processes and outcomes over time. Once final agreement and recommendations on CCO metrics are made, each Board will include applicable metrics, seeking maximum alignment with the needs and vision of PEBB and OEBC for the marketplace, including regular commercial, carve-out, and CCO options in contracts and in future requests for proposals.

Innovations in Payment Methods

The Boards direct carriers to negotiate for rates and methodologies that can provide the highest quality at the lowest cost. Among examples of arrangements specified in PEBB and OEBC contracts and used by carriers to promote improved health outcomes and more rational payment methodologies are the following: case rates, bundled payment rates, prospective payment methods (diagnostic related groups) for hospital services, payments tied to evidence-based treatment guidelines and or outcomes of care, achievement of a standard (PCPCH) and global budgeting. The Boards will review the global budgeting methodology and innovative payment methodologies approved by the Oregon Health Policy Board and adopt those that align with the PEBB and OEBC needs and vision and that are viable to implement with commercial market contractors.

Plan Designs that Emphasize Value

Both Boards seek optimal health for members. Their plans incorporate value-based benefit designs to offer preventive and maintenance medicine and services at no or low cost; conversely, members share a higher portion of the cost of services for preference-sensitive or over-utilized services. Guides for shared decision support educate members about the risks, harms and benefits of treatments, with attention to alternatives to higher-cost, over-utilized treatments that lack evidence of better outcomes. Plan designs by both Boards include no-cost coverage of 17 recommended preventive measures, ranging from infant-through-adult vaccinations to screenings for breast, cervical, colon and prostate cancer. The Boards will review additional preventive measures that the Oregon Health Policy Board approves and adopt those that align with the PEBB and OEBC needs and vision and that are viable to implement with commercial market contractors.

Health Promotion and Prevention

Health promotion and wellness activities are in place at some job sites with plans to expand to additional sites to foster a healthy work culture. Targeted programs include weight management, tobacco cessation (a fully covered benefit) and employee assistance programs to address alcohol and drug addiction and other behavioral health issues. Health promotion and prevention of illness are essential elements of Board programs and Coordinated Care Organizations.

PEBB and OEGB planning

Through House Bill 3650², the legislature requires PEBB and OEGB to consider CCOs as an option for members in the future. PEBB's and, later, OEGB's initial vision for the delivery system was developed between 2004 and 2007. The Oregon Health Authority, formed after PEBB and OEGB last requested proposals from the commercial market, has embraced directives towards achieving the Triple Aim – improve health, improve the member experience of care and reduce costs.

Through a public process, PEBB and OEGB will develop a request for proposals (RFP) that will take into account the PEBB and OEGB vision, objectives and achievements over the past five years; the current health care environment of Oregon; and the goal of furthering the objectives of the Triple Aim.

In early 2012, the PEBB Board with involvement by several OEGB Board members will begin the public planning required to develop an RFP for health benefits beginning 2014. Planning work will address the outline of the RFP, plan design parameters, structure, methods of solicitation, selection criteria, accountability metrics and models for member health engagement. The expectations and metrics currently under development for the CCOs will be integrated into this work. The Boards in coming months will decide on the structure of RFP subcommittees responsible for development of the RFP and evaluation of bidders. The following table summarizes time frames and actions. Lessons from this RFP process and alignment strategies will be included in subsequent OEGB and PEBB RFPs.

² *ibid*

2014 Medical Plan Proposals

| Time Frame | Key Actions |
|---------------------|---|
| February 2012 | PEBB and OEGB provide feedback to OHPB on future RFPs with CCO options. PEBB, through OHA, receives final decisions on CCO criteria from Legislature. |
| January – July 2012 | PEBB makes plan design decisions. PEBB and OEGB hold joint board meetings to discuss the development and design of a PEBB’s request for proposal, outlining expectations, timelines and action steps. |
| | PEBB and OEGB receive regular updates from OHA staff around implementation of CCOs. |
| May- June 2012 | PEBB continues to research and finalize parameters for medical RFP including criteria and metrics from OHA CCO implementation work. |
| March- Sept. 2012 | Develop solicitation work plans, process, timeline, content, scoring and deliverables, which are expected to include, at a minimum, alignment with CCO criteria and metrics. A request for information (RFI) could be fielded to determine the readiness of and risks related to the delivery system and any impacts on quality and cost of care for PEBB/OEGB members. |
| Sept. 2012 | PEBB finalizes RFP structure, including regular commercial bidders, any carve-outs, and CCO plan options |
| Oct. 2012 | PEBB releases RFP, inviting responses from regular commercial bidders, any carve-outs, and CCO plan options. |
| Jan. 2013 | Close acceptance of proposals for plan year 2014. |
| Feb. 2013 | Score and evaluate PEBB RFP proposals. |
| October 2013 | PEBB holds open enrollment for plans with all successful bidders including any regular commercial, carve-out, and or CCO options. OEGB releases RFP with CCO options. |
| March 2014 | OEGB completes selection based on response to RFP. |
| August 2014 | OEGB begins open enrollment. |



CCO Implementation Proposal

Public Comment Summary, Second Round

January 24, 2012

For full text of each comment, please visit: www.oregon.gov/OHA/OHPB/meetings

CCO Implementation Proposal
 Public Comment Summay, Second Round -- January 24, 2012

| PDF Book mark No. | Category | Organization or Person | Comment |
|-------------------|--------------------------------|--|---|
| 18 | Behavioral health | Recovery Advocates United | Mental and behavioral health consumers want to be included in health care reform. OHA should ensure peers are involved in the development of state-level policy. |
| 24 | Behavioral Health | Empower Oregon | Includes panel testimony and breakout group feedback from Empower Oregon's health care forum on January 17th on behavioral health and addictions services. |
| 9 | Behavioral health: Drugs | Estelle Womack | Concerned about not including the cost of mental health drugs in the overall budget. |
| 8 | Behavioral health: Families | Ron Sipress | The CCO plan pays little attention to families with children who have mental and emotional challenges. These families need to be actively involved in their care. |
| 12 | Behavioral health: Integration | Wendy Bourq Ransford (comment was representative of a handful) | It is vital to integrate behavioral health into the care of patients. Outcomes will improve drastically. |
| 21 | CCO Certification | Coos County | Counties should have an active voice in the certification process and on the governing board; Under ADR there should be a method to address the issue of overlapping CCOs in a given geographic area; the authority of the Community Advisory Council should be clarified. |
| 11 | CCO Criteria | Tom Jefferson | Allowing more than one CCO/county will significantly increase the complexity of managing budgets and could eliminate any efficiencies that are expected to be gained. Also, the proposal should address fraud audits. |
| 16 | CCO Criteria | Aisha Kudura | Great plan. How will patients be motivated to make changes in their own health? What will incentivize organizations to become CCOs? Will training be provided to build the community health worker workforce? |
| 26 | CCO Criteria | Northwest Health Foundation | The number of CCOs per region should be specifically limited to one. It should not be acceptable for patients to have to wait 6 to 8 weeks for appointments of to drive 50 miles to another city to see a provider. Recommend that OHA create an application review group. CCOs should have to articulate how major components of the health care delivery system are represented on governing boards. All consumer representatives should be members of the CAC. Clarify the intent of the language around community needs assessment. |
| 27 | CCO Criteria | Sean Riesterer | Want to second Felisa Hagins comments that there is not enough transparency or accountability. These two components need to be strengthened. |

CCO Implementation Proposal
 Public Comment Summay, Second Round -- January 24, 2012

| PDF Book mark No. | Category | Organization or Person | Comment |
|-------------------|-------------------------------|--|---|
| 31 | CCO Criteria, governance | Judge Steven Grasty, Harney County Court | All health providers, individuals and entities should be part of the governing board for a CCO serving our county, or any other county. Partnerships between CCOs and mental health authorities should be strengthened. There needs to be more clarification regarding the global budget methodology, including inclusion and exclusion of funding. Counties should be part of the monitoring and oversight of financial reporting. |
| 10 | CCO Criteria: pain management | Michelle Underwood | A diagnostic support system would be extremely helpful in eliminating provider prejudice, something that is so human we cannot expect them to be without. This would help eliminate waste, and allow pain management to be better controlled and applied. |
| 19 | CCO Criteria: Transportation | Rand Stamm, Lane Transit District | The current human service transportation system is extremely effective and should continue to be an important aspect of the Medicaid system. There is no need to reinvent the wheel or to inadvertently disassemble an effective model. |
| 30 | County roles | Wasco County | Counties should have an active role in the selection of CCOs serving their communities, as well as a role in governance. Will programming currently provided by local government be maintained in the global budget? How will federal matching dollars be obtained if CCOs are not government bodies? Also, there should be assurances that CCOs do not result in cost shifting to counties. |
| 21 | Global Budget | Coos County | A preferred model for achieving Global Budget is to set the statewide budget on a per person, per month basis, and describe how it will be adjusted. |
| 15 | Governance | Mult. Alliance for Common Good (MACG) | One simple request: Require CCO boards to have at least a third of the members be from the community at large, including representation from low income and disadvantaged populations |
| 17 | Governance | Medicaid Advisory Committee | A CCO should have to define their community, so that they can adequately have a board makeup that reflects said community; The CAC member that sits on the board should be a Medicaid consumer. |
| 20 | Governance | Assoc. of Oregon Counties (AOC) | Add language that ensures counties will have a meaningful roll in CCO governance. Additionally, representatives from the counties should be appointed to the Technical Advisory Group that is to be convened. |
| 29 | Governance | Lane County | The "public" seat should have as much authority as the "private" seat on the CCO governing boards. We recommend language similar to what was in SB 204 (2011). |

CCO Implementation Proposal
Public Comment Summay, Second Round -- January 24, 2012

| PDF Book mark No. | Category | Organization or Person | Comment |
|-------------------|-------------------------------|---------------------------------|---|
| 25 | Governance and Counties | Marion County | There needs to be stronger language outlining partnerships between CCOs and county governments. CCOs must have a meaningful roll in governance. Additionally, counties can be a good asset to CCOs by holding public hearings to gather key community input. Counties should be represented on CACs. |
| 23 | Governance and Criteria | Oregon Disabilities Commission | We urge a consistent, well-defined mandated partnership between OHA and the Oregon Disabilities Commission. The CAC member with a disability should be a mandated member of the CCO board. Each CCO should be required to have an ombudsperson. THE ODC should be included in discussions at both the local CCO level and the state level. Consumers must have a choice in the PCPCH. |
| 32 | Governance and Global Budget. | Jackson County | Jackson County would like to review and give input on all CCO applications covering Jackson County. Counties should be on governing boards; Jackson County supports the emphasis on partnerships between local mental health authorities and county government. Global budget issues must be carefully considered, especially regarding federal match dollars. |
| 17 | Health integration | Medicaid Advisory Committee | CCOs should have to emphasize delivery of preventive dental services. They should also conduct health screenings, including behavioral health, for members to assess individual care needs. |
| 28 | Implementation and Transition | Providence Health & Services | Flexibility, efficiency and standardized administration will be essential. Also, Section 9 - transition strategy has the potential to undo a lot of the transformation work due to its vagueness. It is essential that OHA defines transition criteria and early adopter incentives in statute. |
| 22 | Implementation Plan | Oregon Center for Public Policy | Multiple recommendations, including: the implementation plan should reference all relevant legislation; explicit CCO consumer protection obligations; promote accurate service determinations; OHA should strengthen the grievance process; increase accountability measures; OHA should monitor member access to providers; promote improved communication with members. |
| 33 | Innovation agents | Bob Dannenhoffer, DCIPA | I would propose a system that is a cross between the county agricultural extension agent and the original vision of the pre paid health plan coordinator. I would propose that each CCO has an "innovation agent." |

CCO Implementation Proposal
 Public Comment Summay, Second Round -- January 24, 2012

| PDF Book mark No. | Category | Organization or Person | Comment |
|-------------------|--------------------------|---------------------------------|---|
| 4 | Lane County CCO | Wendy Lang | I work at Bethel Student Health Center in the Bethel School District. Our clinic has great potential to improve the health and education of children in this district; we have a fully functioning medical clinic; our mission is to increase the health of the children in the Bethel School District. We would like to see our services included in the Lane County CCO plan. |
| 18 | Metrics and Outcomes | Recovery Advocates United | Outcomes measurements and quality indicators should be the driving force behind reform. Metrics should guide service quality, workforce development, and the availability of evidence-based practices. Words throughout the proposal such as "encourage" or "recommend" are not definitive enough. |
| 1 | Non-discrimination | Oregon Chiropractic Association | CCOs must not be allowed to discriminate against any health care provider practicing within their scope, licensure or certification; Considering the current and increasing health care work force shortage, especially in primary care, Governor Kitzhaber has stated that Oregon will need all health care providers engaged in Oregon's health care reform; the chiropractic profession would submit that part of true health care reform includes moving away from out over-reliance on synthetic pharmacological agents. |
| 6 | Non-discrimination | Michael Gravett | Oregon has an opportunity to take a stance in the correction of a fragmented healthcare delivery system by drafting a plan that begins to truly coordinate medical care by providing coverage for a group of physicians philosophically and medically trained in the concept of "coordinated care." |
| 13 | Non-discrimination | American Massage Therapy Assoc. | Please include non-discrimination language regarding the use, availability, and reimbursement for those health professionals deemed important enough to our citizens to be licensed and entrusted to provide care for Oregonians. |
| 14 | Other | Edward Yanke | This is just another name for managed care, which did not work the first time. |
| 5 | Patients: cost savings | Melissa Kittrell | I've not seen anything in the CCO plans about how the reduction in costs will be passed down to the consumer. How will the steps taken in the next couple years lead to reducing health care costs and more money in the consumers' pockets. |
| 7 | Patients: non compliancy | Alma Smith | Families and patients need to be responsible for themselves in some meaningful way. They should help be a communicator with their doctors. One good manner of "health information exchange" is communication by the patient between providers. |

CCO Implementation Proposal
 Public Comment Summay, Second Round -- January 24, 2012

| PDF Book mark No. | Category | Organization or Person | Comment |
|-------------------|---------------------------------|---|---|
| 3 | Prescription drug overuse | Vern Saboe | How is it that the Oregon Pain Management Commission recommends moving away from opioid narcotics for chronic recurrent lower back pain because of adverse events, but OHP will not pay for less invasive patient preferred intervention? There is a disconnect between what we say we are doing/what we wish to do and what we actually are doing. |
| 2 | Tribal Concerns and Suggestions | Northwest Portland Area Indian Health Board | Covers issues relating to tribal health care and CCOs, including alternative payment methodologies, mandatory enrollment, Indian health benefits package, options for providing specialty care, global budgets, and tribal consultation. |

LC 97
2012 Regular Session
12100-001
1/13/12 (LHF/ps)

DRAFT

SUMMARY

Provides legislative approval of Oregon Health Authority proposals for coordinated care organizations. Requires authority to report quarterly to legislative committees on implementation of coordinated care organization model of health care delivery. Authorizes sharing and use of information between Department of Consumer and Business Services and authority for specified purposes. Prohibits discrimination against types of providers by coordinated care organizations and specified managed care organizations.

Makes technical corrections.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care delivery; creating new provisions; amending ORS 414.033, 414.632, 414.635, 414.740 and 416.540 and sections 14, 62, 63 and 64, chapter 602, Oregon Laws 2011; and declaring an emergency.

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

LEGISLATIVE APPROVAL OF COORDINATED CARE ORGANIZATION PROPOSAL

SECTION 1. The Legislative Assembly approves the proposals presented by the Oregon Health Authority as required by section 13, chapter 602, Oregon Laws 2011.

SECTION 2. Section 14, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 14. (1) Notwithstanding ORS [*414.725 and 414.737*] **414.631** and

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.

1 **414.651**, in any area of the state where a coordinated care organization has
2 not been certified, the Oregon Health Authority shall continue to contract
3 with one or more prepaid managed care health services organizations, as
4 defined in ORS 414.736, that serve the area and that are in compliance with
5 contractual obligations owed to the state or local government.

6 (2) Prepaid managed care health services organizations contracting with
7 the authority under this section are subject to the applicable requirements
8 for, and are permitted to exercise the rights of, coordinated care organiza-
9 tions under [*sections 4, 6, 8, 10 and 12 of this 2011 Act and*] ORS 414.153,
10 **414.625, 414.635, 414.638, 414.651, 414.655, 414.679, 414.712, [414.725,] 414.728,**
11 **414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830**
12 **and 743.847.**

13 (3) The authority may amend contracts that are in place on [*the effective*
14 *date of this 2011 Act*] **July 1, 2011**, to allow prepaid managed care health
15 services organizations that meet the criteria [*approved by the Legislative*
16 *Assembly under section 13 of this 2011 Act*] **adopted by the authority under**
17 **ORS 414.625** to become coordinated care organizations.

18 (4) The authority shall continue to renew the contracts of prepaid man-
19 aged care health services organizations that have a contract with the au-
20 thority on [*the effective date of this 2011 Act*] **July 1, 2011**, until the earlier
21 of the date the prepaid managed care health services organization becomes
22 a coordinated care organization or July 1, 2014. Contracts with prepaid
23 managed care health services organizations must terminate no later than
24 July 1, 2017.

25 (5) The authority shall continue to renew contracts or ensure that coun-
26 ties renew contracts with providers of residential chemical dependency
27 treatment until the provider enters into a contract with a coordinated care
28 organization but no later than July 1, 2013.

29 (6) Notwithstanding [*sections 4 (1)(g) and 6 (2) of this 2011 Act*] **ORS**
30 **414.625 (1)(g) and 414.655 (2)**, the authority shall allow for a period of
31 transition to the full adoption of health information technology by coordi-

1 nated care organizations and patient centered primary care homes. The au-
2 thority shall explore options for assisting providers and coordinated care
3 organizations in funding their use of health information technology.

4 **SECTION 3.** Section 62, chapter 602, Oregon Laws 2011, is amended to
5 read:

6 **Sec. 62.** [(1)] The Oregon Health Authority may not implement any [*pro-*
7 *visions of this 2011 Act that require*] **provision of chapter 602, Oregon**
8 **Laws 2011, that requires** federal approval, or that [*require*] **requires** fed-
9 eral approval to receive federal financial participation, until the authority
10 has received the **federal** approval.

11 [(2) *Until the authority has received the approval of the Legislative As-*
12 *sembly under section 13 of this 2011 Act, the authority may not:*]

13 [(a) *Adopt by rule the qualification criteria for a coordinated care organ-*
14 *ization under section 4 of this 2011 Act or contract with a coordinated care*
15 *organization;*]

16 [(b) *Adopt by rule a global budgeting process or establish global budgets*
17 *for coordinated care organizations; or*]

18 [(c) *Implement a process for financial reporting by coordinated care organ-*
19 *izations or establish financial reporting requirements under ORS 414.725*
20 *(1)(c).*]

21 **SECTION 4.** Section 63, chapter 602, Oregon Laws 2011, is amended to
22 read:

23 **Sec. 63.** The amendments to [*section 8 of this 2011 Act*] **ORS 414.635** by
24 section 9 [*of this 2011 Act*], **chapter 602, Oregon Laws 2011**, become oper-
25 ative [*January 1, 2014*] **on the effective date of this 2012 Act.**

26 **SECTION 5.** ORS 414.635, as amended by section 9, chapter 602, Oregon
27 Laws 2011, is amended to read:

28 414.635. (1) The Oregon Health Authority shall adopt by rule safeguards
29 for members enrolled in coordinated care organizations that protect against
30 underutilization of services and inappropriate denials of services. In addition
31 to any other consumer rights and responsibilities established by law, each

1 member:

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

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

6 (c) Must have access to advocates, including qualified peer wellness spe-
7 cialists where appropriate, personal health navigators, and qualified com-
8 munity health workers who are part of the member's care team to provide
9 assistance that is culturally and linguistically appropriate to the member's
10 need to access appropriate services and participate in processes affecting the
11 member's care and services.

12 (d) Shall be encouraged within all aspects of the integrated and coordi-
13 nated health care delivery system to use wellness and prevention resources
14 and to make healthy lifestyle choices.

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

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

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

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

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

30 (4) A health care entity may not unreasonably refuse to contract with an
31 organization seeking to form a coordinated care organization if the partic-

1 ipation of the entity is necessary for the organization to qualify as a coor-
2 dinated care organization.

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

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

11 (7) The authority shall maintain the process[, *approved by the Legislative*
12 *Assembly,*] for resolving disputes involving an entity's refusal to contract
13 with a coordinated care organization under subsections (4) and (5) of this
14 section. The process must include the use of an independent third party
15 arbitrator.

16 (8) A coordinated care organization may not unreasonably refuse to con-
17 tract with a licensed health care provider.

18 (9) The authority shall:

19 (a) Monitor and enforce consumer rights and protections within the
20 Oregon Integrated and Coordinated Health Care Delivery System and ensure
21 a consistent response to complaints of violations of consumer rights or pro-
22 tections.

23 (b) Monitor and report on the statewide health care expenditures and re-
24 commend actions appropriate and necessary to contain the growth in health
25 care costs incurred by all sectors of the system.

26

27

**IMPLEMENTATION OF OREGON INTEGRATED
AND COORDINATED CARE DELIVERY SYSTEM**

28

29

30 **SECTION 6. (1) The Department of Consumer and Business Services**
31 **and the Oregon Health Authority may enter into agreements govern-**

1 ing the disclosure of information reported to the department by
2 insurers with certificates of authority to transact insurance in this
3 state.

4 (2) The authority may use information disclosed under subsection
5 (1) of this section for the purpose of carrying out ORS 414.625, 414.635,
6 414.638, 414.645 and 414.651.

7 SECTION 7. Section 8 of this 2012 Act is added to and made a part
8 of ORS chapter 414.

9 SECTION 8. (1) A fully capitated health plan, physician care or-
10 ganization or coordinated care organization may not discriminate in
11 the participation or reimbursement of any health care provider based
12 on the provider's license or certification if the provider is acting
13 within the scope of the provider's license or certification. A plan or
14 organization must give written notice containing the reasons for its
15 action if the plan or organization declines the participation of any
16 provider or group of providers.

17 (2) Subsection (1) of this section does not:

18 (a) Require a plan or organization to contract with more providers
19 than are necessary to meet the needs of its members;

20 (b) Preclude the plan or organization from using different re-
21 imbursement amounts for different specialties or different practition-
22 ers in the same specialty; or

23 (c) Preclude the plan or organization from establishing measures
24 that are designed to maintain the quality of services and control costs
25 and are consistent with the plan's or organization's responsibilities to
26 its members.

27 SECTION 9. Section 8 of this 2012 Act is amended to read:

28 **Sec. 8.** (1) A [*fully capitated health plan, physician care organization or*]
29 coordinated care organization may not discriminate in the participation or
30 reimbursement of any health care provider based on the provider's license
31 or certification if the provider is acting within the scope of the provider's

1 license or certification. [A *plan or*] An organization must give written notice
 2 containing the reasons for its action if the [*plan or*] organization declines
 3 the participation of any provider or group of providers.

4 (2) Subsection (1) of this section does not:

5 (a) Require [*a plan or*] an organization to contract with more providers
 6 than are necessary to meet the needs of its members;

7 (b) Preclude the [*plan or*] organization from using different reimbursement
 8 amounts for different specialties or different practitioners in the same spe-
 9 cialty; or

10 (c) Preclude the [*plan or*] organization from establishing measures that
 11 are designed to maintain the quality of services and control costs and are
 12 consistent with the [*plan's or*] organization's responsibilities to its members.

13 **SECTION 10.** The amendments to section 8 of this 2012 Act by sec-
 14 tion 9 of this 2012 Act become operative July 1, 2017.

15 **SECTION 11.** In each calendar quarter, the Oregon Health Author-
 16 ity shall report to the appropriate committees or interim committees
 17 of the Legislative Assembly on the implementation of the Oregon In-
 18 tegrated and Coordinated Care Delivery System.

19 **SECTION 12.** Section 11 of this 2012 Act is repealed July 1, 2017.

20

21 **TECHNICAL CORRECTIONS AND CONFORMING AMENDMENTS**

22

23 **SECTION 13.** Section 64, chapter 602, Oregon Laws 2011, as amended by
 24 section 70, chapter 602, Oregon Laws 2011, is amended to read:

25 **Sec. 64.** (1) ORS 414.705 is repealed.

26 (2) Sections 13[, 14] and 17 [*of this 2011 Act*], chapter 602, Oregon Laws
 27 2011, are repealed January 2, 2014.

28 (3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739 and 414.740 are
 29 repealed July 1, 2017.

30 (4) Section 14, chapter 602, Oregon Laws 2011, as amended by section
 31 2 of this 2012 Act, is repealed July 1, 2017.

1 **SECTION 14.** ORS 414.033 is amended to read:

2 414.033. The Oregon Health Authority may:

3 (1) Subject to the allotment system provided for in ORS 291.234 to 291.260,
4 expend such sums as are required to be expended in this state to provide
5 medical assistance. Expenditures for medical assistance include, but are not
6 limited to, expenditures for deductions, cost sharing, enrollment fees, premi-
7 ums or similar charges imposed with respect to hospital insurance benefits
8 or supplementary health insurance benefits, as established by federal law.

9 (2) Enter into agreements with, join with or accept grants from[,] the
10 federal government for cooperative research and demonstration projects for
11 public welfare purposes, including, but not limited to, any project for:

12 (a) Providing medical assistance to individuals who are dually eligible for
13 Medicare and Medicaid using **global or** alternative payment methodologies
14 or integrated and coordinated health care and services; or

15 (b) Evaluating service delivery systems.

16 **SECTION 15.** ORS 414.632 is amended to read:

17 414.632. (1) Subject to the Oregon Health Authority obtaining any neces-
18 sary authorization from the Centers for Medicare and Medicaid Services
19 [*under section 17, chapter 602, Oregon Laws 2011*], coordinated care organ-
20 izations that meet the criteria adopted under ORS 414.625 are responsible for
21 providing covered Medicare and Medicaid services, other than Medicaid-
22 funded long term care services, to members who are dually eligible for
23 Medicare and Medicaid in addition to medical assistance recipients.

24 (2) An individual who is dually eligible for Medicare and Medicaid shall
25 be permitted to enroll in and remain enrolled in a:

26 (a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R.
27 460.6; and

28 (b) [A] Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the
29 plan is fully integrated into a coordinated care organization.

30 (3) Except for the enrollment in coordinated care organizations of indi-
31 viduals who are dually eligible for Medicare and Medicaid, the rights and

1 benefits of Medicare beneficiaries under Title XVIII of the Social Security
2 Act shall be preserved.

3 **SECTION 16.** ORS 414.740 is amended to read:

4 414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Author-
5 ity shall contract under ORS 414.651 with a prepaid group practice health
6 plan that serves at least 200,000 members in this state and that has been is-
7 sued a certificate of authority by the Department of Consumer and Business
8 Services as a health care service contractor to provide health services as
9 described in ORS [414.705 (1)(b)] **414.025 (8)(b)**, (c), (d), (e), (g) and (j). A
10 health plan may also contract with the authority on a prepaid capitated basis
11 to provide the health services described in ORS [414.705 (1)(k)] **414.025 (8)(k)**
12 and (L). The authority may accept financial contributions from any public
13 or private entity to help implement and administer the contract. The au-
14 thority shall seek federal matching funds for any financial contributions re-
15 ceived under this section.

16 (2) In a designated area, in addition to the contract described in sub-
17 section (1) of this section, the authority shall contract with prepaid managed
18 care health services organizations to provide health services under ORS
19 414.631, 414.651 and 414.688 to 414.750.

20 **SECTION 17.** ORS 416.540 is amended to read:

21 416.540. (1) Except as provided in subsection (2) of this section and in ORS
22 416.590, the Department of Human Services and the Oregon Health Authority
23 shall have a lien upon the amount of any judgment in favor of a recipient
24 or amount payable to the recipient under a settlement or compromise for all
25 assistance received by such recipient from the date of the injury of the re-
26 cipient to the date of satisfaction of such judgment or payment under such
27 settlement or compromise.

28 (2) The lien does not attach to the amount of any judgment, settlement
29 or compromise to the extent of attorney's fees, costs and expenses incurred
30 by a recipient in securing such judgment, settlement or compromise and to
31 the extent of medical, surgical and hospital expenses incurred by the recipi-

1 ent on account of the personal injuries for which the recipient had a claim.

2 (3) The authority may assign the lien described in subsection (1) of this
3 section to a prepaid managed care health services organization or a coordi-
4 nated care organization for medical costs incurred by a recipient:

5 (a) During a period for which the authority paid a capitation or enroll-
6 ment fee or a payment using *[an alternative]* a **global** payment methodology;
7 and

8 (b) On account of the personal injury for which the recipient had a claim.

9 (4) A prepaid managed care health services organization or a coordinated
10 care organization to which the authority has assigned a lien shall notify the
11 authority no later than 10 days after filing notice of a lien.

12 (5) For the purposes of ORS 416.510 to 416.610, the authority may desig-
13 nate the prepaid managed care health services organization or the coordi-
14 nated care organization to which a lien is assigned as its designee.

15 (6) If the authority and a prepaid managed care health services organ-
16 ization or a coordinated care organization both have filed a lien, the
17 authority's lien shall be satisfied first.

18 **SECTION 18. ORS 414.631, 414.651 and 414.688 to 414.750 are added to**
19 **and made a part of ORS chapter 414.**

20
21 **CAPTIONS**

22
23 **SECTION 19. The unit captions used in this 2012 Act are provided**
24 **only for the convenience of the reader and do not become part of the**
25 **statutory law of this state or express any legislative intent in the**
26 **enactment of this 2012 Act.**

27
28 **EMERGENCY CLAUSE**

29
30 **SECTION 20. This 2012 Act being necessary for the immediate**
31 **preservation of the public peace, health and safety, an emergency is**

1 **declared to exist, and this 2012 Act takes effect on its passage.**

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LC 97 Non-Discrimination Clause vs Existing Medicaid Rule

Transformation Bill: LC 97, Section 8

- (1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. A plan or organization must give written notice containing the reasons for its action if the plan or organization declines the participation of any provider or group of providers.
- (2) Subsection (1) of this section does not:
 - (a) Require a plan or organization to contract with more providers than are necessary to meet the needs of its members;
 - (b) Preclude the plan or organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or
 - (c) Preclude the plan or organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the plan's or organization's responsibilities to its members.

Existing Medicaid Rule: 42 CFR 438.12

Note: This Medicaid rule applies to managed care organizations (MCO), which is broadly defined in federal rule as an organization contracting for risk. Our understanding is that this rule applies to current MCOs and would also apply to CCOs.

- (a) *General rules.*
 - (1) An MCO or PHP may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO or PHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
 - (2) In all contracts with health care professionals an MCO or PHP must comply with the requirements specified in § 438.214.
- (b) *Construction.* Paragraph (a) of this section may not be construed to—
 - (1) Require the MCO or PHP to contract with providers beyond the number necessary to meet the needs of its enrollees;
 - (2) Preclude the MCO or PHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 - (3) Preclude the MCO or PHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

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| Applicability and Statute, Rule | Language |
|--|--|
| LC 97 | <p>(1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. A plan or organization must give written notice containing the reasons for its action if the plan or organization declines the participation of any provider or group of providers.</p> <p>(2) Subsection (1) of this section does not:</p> <p>(a) Require a plan or organization to contract with more providers than are necessary to meet the needs of its members;</p> <p>(b) Preclude the plan or organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or</p> <p>(c) Preclude the plan or organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the plan's or organization's responsibilities to its members.</p> <p><i>Note: This language is based on and attempts to model the current protection in federal rules (42 CFR 438.12 below) which apply to MCOs (and we believe would apply to CCOs too). This section is also fairly consistent with the requirements of Medicare Advantage Plans (below).</i></p> |
| Medicaid | |
| <p>Oregon Medicaid</p> <p>ORS 685.055 & HB 3650</p> | <p>There is no provision specific to all Medicaid regarding provider non-discrimination in Oregon statute. There is a provision that applies to OHA regarding only naturopathic physician:</p> <p>ORS 685.055: "The Director of the Oregon Health Authority may not discriminate between licensed naturopathic physicians and any other person authorized by law to render professional services that a licensed naturopathic physician may render, when such services are required. If the Oregon Health Authority is responsible for paying for such services, the services shall be paid for in the same manner and under the same standards as similar professional services."</p> <p>HB 3650, Section 8, subsection 8 reads: "A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider."</p> |
| <p>Federal Medicaid Rules</p> <p>42 CFR 438.12</p> | <p>§ 438.12 Provider discrimination prohibited.</p> <p>(a) General rules. (1) An MCO or PHP may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO or PHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.</p> <p>(2) In all contracts with health care professionals an MCO or PHP must comply with the requirements specified in § 438.214.</p> <p>(b) Construction. Paragraph (a) of this section may not be construed to—</p> <p>(1) Require the MCO or PHP to contract with providers beyond the number necessary to meet the needs of its enrollees;</p> <p>(2) Preclude the MCO or PHP from using different reimbursement amounts for different specialties or for different practitioners in the</p> |

| | |
|--|---|
| | <p>same specialty; or (3) Preclude the MCO or PHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.</p> <p>Note: This provision applies to managed care organizations (MCO), which under the federal rule is broadly defined as an organization contracting for risk. This rule currently applies to Oregon MCOs, and our understanding is that this would also apply to CCOs. This section also incorporates requiring compliance with 42 CFR 438.214 (not included in LC 97, but still applicable under the federal rule).</p> <p>§ 438.214 Provider selection. (a) General rules. The State must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of this section. (b) Credentialing and recredentialing requirements. (1) Each State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. (2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO, PIHP, or PAHP. (c) Nondiscrimination. MCO, PIHP, and PAHP provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (d) Excluded providers. MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (e) State requirements. Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.</p> |
| <p>Note: Exclusion of Providers</p> | <p>All publicly funded programs require the exclusion of individuals due to license suspension, or due to conviction of certain crimes including fraud. Fraud and abuse provisions may apply to prevent individuals or entities from participating, unrelated to the scope of licensure.</p> |
| <p>Medicare</p> | |
| <p>Medicare Advantage Plans 42 CFR 422.205</p> | <p>§ 422.205 Provider antidiscrimination rules. (a) General rule. Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under §422.204, and with the requirement under §422.100(c) that all Medicare-covered services be available to MA plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision. (b) Construction. The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization: (1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's</p> |

| | |
|---|---|
| | <p>enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).</p> <p>(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.</p> <p>(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.</p> |
| Commercial Plans | |
| <p>Commercial Market (Oregon)</p> <p>ORS chapter 743a</p> | <p>Nothing comparable to LC 97, but there are some specific provisions applicable to commercial health insurers when a policy provides for certain types of coverage of services provided within scope of practice (e.g., acupuncturists, denturists, nurse practitioners, optometrists, etc.).</p> |
| <p>Commercial Market (Federal)</p> <p>ACA § 1201 inserting §2706 into the Public Health Service Act. (Amended 42 USC §300gg)</p> <p>Effective date: January 1, 2014 (per §1255)</p> | <p>Subtitle C—Quality Health Insurance Coverage for All Americans</p> <p>PART 1—HEALTH INSURANCE MARKET REFORMS</p> <p>“SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.</p> <p>“(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation establish by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.</p> <p>“(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.</p> |