Division of Medical Assistance Programs

John A. Kitzhaber, MD, Governor

Oregon Health Authority

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June 26, 2013

Terri Fraser, Project Officer
Centers for Medicare and Medicaid Services
By electronic mail: terri.fraser@cms.hhs.gov

Dear Ms. Fraser,

Since 1994, Oregon has operated a Medicaid demonstration program, the Oregon Health Plan (OHP)[1], under section 1115 of the Social Security Act. The demonstration currently provides health coverage to more than 600,000 Oregonians.

Oregon requests approval from the Centers for Medicare and Medicaid Services (CMS) to amend Oregon's section 1115 Medicaid demonstration to reflect proposed changes that would enhance the access to and the quality of health care for those on the Oregon Health Plan. The waiver request consists of two proposals—the Hospital Access to Care Program and the Hospital Transformation Performance Program. Please consider these two programs for approval separately as they are not interdependent on one another.

Governor Kitzhaber and the Oregon Legislature are in full support for these programs. Prior to the 2013 legislative session, the Governor's Office and hospital representatives collaboratively developed these programs and the Governor included them in his 2013-2015 Balanced Budget. For the 2013 legislative session, the Governor filed House Bill 2216 to provide the statutory framework for these programs. During the session, the Oregon Legislature held committee hearings on the bill, allowing public testimony and comment throughout the entire process. The Oregon Legislature passed the bill into law on June 26. House Bill 2216 is attached.

Hospital Access to Care Program

Our request for the Hospital Access to Care Program is related to our current provider assessment on diagnostic related group (DRG) hospitals[2] and our method of reimbursing them through managed care organizations (MCOs), including Coordinated Care Organizations (CCOs). As a component of the capitation rate, the Oregon Health Authority identifies and pays a "hospital reimbursement adjustment" (HRA) to the MCOs/CCOs.

[1] http://www.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf
[2] Oregon hospitals that are reimbursed by Medicare based on diagnostic related groups are subject to the hospital assessment and referred to as DRG hospitals.

The MCOs/CCOs pay this adjustment as a form of enhanced reimbursement to the DRG hospitals that provide services to their enrollees. The state share of this adjustment is fully funded by hospital assessment revenue.

The Oregon Health Authority requests approval to end the HRA and replace it with the Hospital Access to Care Program as a new form of enhanced reimbursement. Under the new program, the authority would make payments directly to DRG hospitals, rather than through MCOs/CCOs.

The state share of these payments would continue to be fully funded by hospital assessment revenue. Program payments would be based on each DRG hospital's actual uncompensated care costs for serving Medicaid and uninsured individuals. To document the uncompensated care costs, each hospital would be required to adhere to a uniform set of instructions used to calculate their uncompensated care, in accordance with Medicare costs reporting principles. The new payment structure would help to ensure continued access to critical hospital services for Oregon Health Plan recipients.

In amending Oregon's section 1115 Medicaid demonstration to include the Hospital Access to Care Program, the Oregon Health Authority respectfully proposes the following as new Special Terms and Conditions:

- Effective October 1, 2013, the Hospital Access to Care Program will be established.

- All hospitals that were previously eligible under the HRA program (i.e., DRG hospitals) will be eligible for payments under the Hospital Access to Care Program.

- The Hospital Access to Care Program will be limited to the undercompensated and uncompensated hospital (inpatient and outpatient) and non-hospital costs (physician, other professional, pharmacy, provider-based clinic) of serving Medicaid and uninsured individuals.

- The Hospital Access to Care Program is eligible for Federal matching (at FMAP rate) under the Cost Not Otherwise Matchable (CNOM) provision of section 1115(a)(2) as part of the Medicaid demonstration.

- All hospitals eligible under the Hospital Access to Care Program are required to complete an uncompensated care cost workbook that identifies costs on a cost-center specific basis, in accordance with Medicare costs reporting principles, and entirely consistent with the required cost calculations under the federal Medicaid DSH audit regulation.

- The State of Oregon will furnish the workbook of each eligible hospital to CMS for its review. The base year for eligible uncompensated care costs will be state fiscal year 2011 (July 1, 2010 – June 30, 2011). For each subsequent HACP payment year, the base period will be moved forward by one year.

- The Hospital Access to Care Program will be effective during period October 1, 2013, through the duration of the Oregon's section 1115 Medicaid demonstration, provided the Oregon legislature authorizes the program's continuation.

- Spending under the Hospital Access to Care Program is not taken into account for purposes of measuring the two-percentage point reduction in the per capita growth rate of spending under the demonstration.

Hospital Transformation Performance Program

Under this proposal, the authority would establish a Hospital Transformation Performance Program using hospital assessment revenue to allow DRG hospitals to earn incentive payments by meeting specific performance objectives. The performance objective would be designed to advance health system transformation, reduce hospital costs, and improve patient safety. The concept is to create a mutually beneficial system for both hospitals as well as CCOs by reducing costs while improving quality.

As specified in House Bill 2216, the Director of the Oregon Health Authority, after consulting with the President of the Oregon Senate and Speaker of the Oregon House, will appoint a hospital performance advisory committee to create and recommend three to five performance standards. The committee will include four members who represent hospitals, three members who have expertise in measuring health outcomes, and two members who represent CCOs.

The funding for the performance program will be provided by an additional one-percentage point increase in the hospital assessment rate. The increase in the assessment will provide the state share of funding for Medicaid matched performance payments, totaling approximately $280 million to qualifying hospitals during the two-year program. According to House Bill 2216, the authority is required to distribute 50 percent of the moneys from the program based upon each hospital's compliance with data submission requirements and 50 percent based upon each hospital's achievement of the performance standards adopted by the authority from those recommended by the hospital performance metrics advisory committee.

In amending Oregon's section 1115 Medicaid demonstration to include the Hospital Transformation Performance Program, the Oregon Health Authority respectfully proposes the following as new Special Terms and Conditions:

- Effective October 1, 2013, the Hospital Transformation Performance Program (HTPP) will be established.

- All hospitals that were previously eligible under the HRA program (i.e., DRG hospitals) will be eligible to participate in the Hospital Transformation Performance Program.

- The Hospital Transformation Performance Program is eligible for Federal matching (at FMAP rate) under the Cost Not Otherwise Matchable (CNOM) provision of section 1115(a)(2) as part of the Medicaid demonstration.

- Eligible hospitals can access money by meeting performance or improvement benchmarks.

- Performance payments to qualifying hospitals will occur at least annually.

- All money allocated for the Hospital Transformation Performance Program each year is distributed in its entirety for that year.

- Hospital Transformation Performance Program payments are intended to support and reward hospital systems for improvements in their delivery systems that advance health system transformation, reduce hospital costs, and improve patient safety. The payments are not reimbursement for health care services. The payments are not be considered patient care revenue and are not offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care as defined under these Special Terms and Conditions, and/or under the State Plan.

- The Hospital Transformation Performance Program will be effective during period October 1, 2013, through the duration of Oregon's section 1115 Medicaid demonstration, provided the Oregon legislature authorizes the program's continuation.

- Spending under the Hospital Transformation Performance Program is not taken into account for purposes of measuring two-percentage point reduction in the per capita growth rate of spending under the demonstration.

Tribal Consultation & Public Process

As required, the Oregon Health Authority consulted with Oregon Tribal representatives on this amendment request. The programs were discussed with Tribal representatives during our Tribal Consultation meeting on Tuesday, January 15, 2013. The authority also sent the attached letter summarizing both programs and requesting comments. The authority received no questions or comments as a result of the letter.

As mentioned above, the Governor filed House Bill 2216 for the 2013 legislative session after discussions with hospital representatives in developing his 2013-15 Balanced Budget. The Oregon Legislature held several committee hearings on the bill, allowing public testimony and comment throughout the process. The Oregon House approved the bill on a 54 to 5 vote. The Oregon Senate approved the bill on a 25 to 5 vote.

Conclusion

Oregon's Medicaid demonstration has proven to be a valuable framework to provide health coverage to low-income Oregonians. It is our belief these two programs will enable DRG hospitals to more effectively and efficiently provide care to OHP recipients. In addition, the Hospital Transformation Performance Program will facilitate collaboration in reducing hospital costs while simultaneously advancing health system transformation and improving patient safety—not just for Medicaid enrollees—but all Oregonians. A background paper that provides additional information about the programs is attached along with the budget neutrality calculations.

Our desire is to work collaboratively with CMS in moving this amendment request through clearance as quickly as possible. Oregon plans to implement the programs by October 1, 2013. In order to accomplish this goal, we respectfully request expedited CMS review and approval.

Thank you in advance for your expedited review of this amendment request. If you have any questions or would like further information, please do not hesitate to contact me at (503) 945-5768.

Sincerely,

Judy Mohr Peterson
Director, Division of Medical Assistance Programs
Oregon Health Authority

CC: Bruce Goldberg, Oregon Health Authority
Michael Bonetto, Governor's Health Policy Advisor
Cindy Mann, Administrator, CMS
Carol J.C. Peverly, CMS, Region 10
Gary Ashby, CMS, Region 10

B-Engrossed
House Bill 2216

Ordered by the House May 10
Including House Amendments dated March 14 and May 10

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor John A. Kitzhaber, M.D.)

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.

Extends sunset on collection of hospital assessment to September 30, 2015. Modifies payment methodology for reimbursement of specified hospitals by state medical assistance program. Authorizes quality improvement incentive payments to hospitals that meet standards adopted by Oregon Health Authority based on recommendations from hospital performance metrics advisory committee.

Establishes process for reducing excess long term care facility bed capacity statewide. Grants antitrust immunity to long term care facilities that participate in process. Modifies procedure for review of applications for certificates of need by long term care facilities.

Modifies long term care facility assessment and long term care facility reimbursement formula. Makes waivered long term care facilities, including long term care facilities operated by continuing care retirement communities, subject to long term care facility assessment. Extends long term care facility assessment to July 1, 2020.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to state medical assistance program funding; creating new provisions; amending ORS 414.746, 442.015 and 442.315 and sections 2, 3, 6, 7, 8, 9, 10, 12, 13, 18, 23, 24 and 31, chapter 736, Oregon Laws 2003; repealing ORS 414.746; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

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

SECTION 1. (1) As used in this section, "hospital" means a hospital that is subject to the assessment imposed under section 2, chapter 736, Oregon Laws 2003.

(2) In consultation with the President of the Senate and the Speaker of the House of Representatives, the Director of the Oregon Health Authority shall appoint a hospital performance metrics advisory committee consisting of nine members, including:

(a) Four members who represent hospitals;

(b) Three members who have expertise in measuring health outcomes; and

(c) Two members who represent coordinated care organizations.

(3) The hospital performance metrics advisory committee shall recommend three to five performance standards that are reasonably attainable by hospitals within the biennium beginning July 1, 2013, and that are consistent with state and national quality standards.

(4) The Oregon Health Authority shall adopt by rule the procedures for distributing to hospitals the moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, to ensure that such moneys are distributed as follows:

(a) The authority shall distribute 50 percent of the moneys based upon each hospital's

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.

compliance with data submission requirements.

(b) The authority shall distribute the remainder of the moneys based upon each hospital's achievement of the performance standards recommended by the hospital performance metrics advisory committee under subsection (3) of this section.

SECTION 2. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, section 51, chapter 828, Oregon Laws 2009, and section 17, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state that is not a waivered hospital. The assessment shall be imposed at a rate determined by the Director of the Oregon Health Authority by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.

(2) The assessment shall be reported on a form prescribed by the Oregon Health Authority and shall contain the information required to be reported by the authority. The assessment form shall be filed with the authority on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection (6) of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

(3)(a) To the extent permitted by federal law, aggregate assessments imposed under this section may not exceed the total of the following amounts received by the hospitals that are reimbursed by Medicare based on diagnostic related groups:

[*(A) The adjustment to the capitation rate paid to Medicaid managed care organizations under section 15, chapter 867, Oregon Laws 2009;*]

[*(B)*] **(A)** 30 percent of payments made to **the** hospitals on a fee-for-service basis by the authority for inpatient hospital services; [*and*]

[*(C)*] **(B)** 41 percent of payments made to **the** hospitals on a fee-for-service basis by the authority for outpatient hospital services[.]**; and**

(C) Payments made to the hospitals using a payment methodology established by the authority that advances the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (3).

(b) Notwithstanding paragraph (a) of this subsection, aggregate assessments imposed for the biennium beginning July 1, [*2009*] **2013**, may exceed the total of the amounts described in paragraph (a) of this subsection to the extent necessary to compensate for any reduction of funding in the legislatively adopted budget for that biennium for hospital services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**.

(4) Notwithstanding subsection (3) of this section, a hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

(5) Hospitals operated by the United States Department of Veterans Affairs and pediatric specialty hospitals providing care to children at no charge are exempt from the assessment imposed under this section.

(6)(a) The authority shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, [*2013*] **2015**, that will result in the collection occurring between December 15, [*2013*] **2015**, and the time all Medicaid cost settlements are finalized for that calendar

quarter.

(b) The authority shall prescribe by rule criteria for late payment of assessments.

SECTION 3. Section 3, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 3. (1) Notwithstanding section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003**, the Director of [*Human Services*] **the Oregon Health Authority** shall reduce the rate of assessment imposed under section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003,** to the maximum rate allowed under federal law if the reduction is required to comply with federal law.

(2) If federal law requires a reduction in the rate of assessments, the director shall, after consulting with representatives of the hospitals that are subject to the assessments, first reduce the distribution of moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, by a corresponding amount.

SECTION 4. Section 6, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 6. (1) Any hospital that has paid an amount that is not required under sections 1 to 9**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003,** may file a claim for refund with the [*Department of Human Services*] **Oregon Health Authority**.

(2) Any hospital that is aggrieved by an action of the [*Department of Human Services*] **authority** or by an action of the Director of [*Human Services*] **the Oregon Health Authority** taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183.

SECTION 5. Section 7, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 7. The [*Department of Human Services*] **Oregon Health Authority** may audit the records of any hospital in this state to determine compliance with sections 1 to 9**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003, and section 1 of this 2013 Act**. The [*department*] **authority** may audit records at any time for a period of five years following the date an assessment is due to be reported and paid under section 2**,** [*of this 2003 Act*] **chapter 736, Oregon Laws 2003**.

SECTION 6. Section 8, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 757, Oregon Laws 2005, is amended to read:

Sec. 8. Amounts collected by the [*Department of Human Services*] **Oregon Health Authority** from the assessments imposed under section 2, chapter 736, Oregon Laws 2003, shall be deposited in the Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003.

SECTION 7. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, section 19, chapter 867, Oregon Laws 2009, and section 59, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of**:**

(a) Paying refunds due under section 6, chapter 736, Oregon Laws 2003 [, *and*]**;**

(b) Funding services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**, including but not limited to[*:*]

[*(a)*] increasing reimbursement rates for inpatient and outpatient hospital services under ORS [*414.705 to 414.750*] **414.631, 414.651 and 414.688 to 414.750**;

[*(b) Maintaining, expanding or modifying services for persons described in ORS 414.025 (3)(s);*]

[*(c) Maintaining or increasing the number of persons described in ORS 414.025 (3)(s) who are enrolled in the medical assistance program; and*]

[*(d)*] **(c) Making payments described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003;**

(d) Making distributions, as described in section 1 (4) of this 2013 Act, of an amount of moneys equal to the federal financial participation received from one percentage point of the rate assessed under section 2, chapter 736, Oregon Laws 2003; and

(e) Paying administrative costs incurred by the authority to administer **section 1 of this 2013 Act and** the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (3)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

SECTION 8. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, and section 20, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals during a period beginning October 1, [*2009*] **2013**, and ending the earlier of September 30, [*2013*] **2015**, or the date on which the assessment no longer qualifies for federal [*matching funds*] **financial participation** under Title XIX **or XXI** of the Social Security Act.

SECTION 9. Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780, Oregon Laws 2007, and section 21, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 12. Sections 1 to 9, chapter 736, Oregon Laws 2003, **and section 1 of this 2013 Act** are repealed on January 2, [*2015*] **2017**.

SECTION 10. Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, and section 22, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 13. Nothing in the repeal of sections 1 to 9, chapter 736, Oregon Laws 2003, **and section 1 of this 2013 Act** by section 12, chapter 736, Oregon Laws 2003, affects the imposition and collection of a hospital assessment under sections 1 to 9, chapter 736, Oregon Laws 2003, for a calendar quarter beginning before September 30, [*2013*] **2015**.

SECTION 11. ORS 414.746 is amended to read:

414.746. (1) The Oregon Health Authority [*shall*] **may** establish an adjustment to the payments made to a coordinated care organization [*defined in section 9, chapter 867, Oregon Laws 2009*].

(2) The contracts entered into between the authority and coordinated care organizations [*must*] **may** include provisions that ensure that the adjustment to the payments established under subsection (1) of this section is distributed by the coordinated care organizations to hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups.

[*(3) The adjustment to the capitation rate paid to coordinated care organizations shall be established in an amount consistent with the legislatively adopted budget and the aggregate assessment imposed pursuant to section 2, chapter 736, Oregon Laws 2003.*]

SECTION 12. ORS 414.746 is repealed.

SECTION 13. (1) The Director of the Oregon Health Authority shall apply to the federal Centers for Medicare and Medicaid Services for any approval necessary to secure federal financial participation in the distributions described in section 9 (2)(d), chapter 736, Oregon Laws 2003, as amended by section 7 of this 2013 Act, and in using the payment methodology described in section 2 (3)(a)(C), chapter 736, Oregon Laws 2003, as amended by section 2 of this 2013 Act.

(2) The Director of the Oregon Health Authority shall immediately notify the Legislative Counsel upon receipt of federal approval or disapproval under this section.

SECTION 14. Section 15 of this 2013 Act is added to and made a part of ORS chapter 442.

SECTION 15. (1) The Legislative Assembly finds that:

(a) A significant amount of public and private funds are expended each year for long term care services provided to Oregonians;

(b) Oregon has established itself as the national leader in providing a choice of noninstitutional care to low income Oregonians in need of long term care services by developing an extensive system of home health care and community-based care; and

(c) Long term care facilities continue to provide critical services to some of Oregon's most frail and vulnerable residents with complex needs. Increasingly, long term care facilities are filling a need for transitional care between hospitals and home settings in a cost-effective manner, reducing the overall costs of long term care.

(2) The Legislative Assembly declares its support for collaboration among state agencies that purchase health services and private health care providers in order to align financial incentives with the goals of achieving better patient care and improved health status while restraining growth in the per capita cost of health care.

(3) It is the goal of the Legislative Assembly that the long term care facility bed capacity in Oregon be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veterans' Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013.

(4) In order to reduce the long term care facility bed capacity statewide, the Department of Human Services may permit an operator of a long term care facility to purchase another long term care facility's entire bed capacity if:

(a) The long term care facility bed capacity being purchased is not in an essential long term care facility; and

(b) The long term care facility's entire bed capacity is purchased and the seller agrees to surrender the long term care facility's license on the earlier of the date that:

(A) The last resident is transferred from the facility; or

(B) Is 180 days after the date of purchase.

(5) If a long term care facility's entire bed capacity is purchased, the facility may not admit new residents to the facility except in accordance with criteria adopted by the Department of Human Services by rule.

(6) Long term care bed capacity purchased under this section may not be transferred to another long term care facility.

(7) The Department of Human Services may convene meetings with representatives of entities that include, but are not limited to, long term care providers, nonprofit trade associations and state and local governments to collaborate in strategies to reduce long term care facility bed capacity statewide. Participation shall be on a voluntary basis. Meetings shall be held at a time and place that is convenient for the participants.

(8) The Department of Human Services may conduct surveys of entities and individuals specified in subsection (7) of this section concerning current long term care facility bed capacity and strategies for increasing future capacity.

(9) Based on the findings in subsection (1) of this section and the declaration expressed in subsection (2) of this section, the Legislative Assembly declares its intent to exempt from state antitrust laws and provide immunity from federal antitrust laws through the state action doctrine individuals and entities that engage in transactions, meetings or surveys described in subsections (4), (7) and (8) of this section that might otherwise be constrained by such laws.

(10) The Director of Human Services or the director's designee shall engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the individuals and entities acting pursuant to subsection (4), (7) or (8) of this section are acting in accordance with the legislative intent expressed in this section.

(11) The Director of Human Services or the director's designee, in consultation with the Long Term Care Ombudsman, shall engage in regional planning necessary to promote the safety and dignity of residents living in a long term care facility that surrenders its license under this section.

SECTION 16. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

[*(4) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.*]

[*(5)*] **(4)** "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

(5) "Essential long term care facility" means an individual long term care facility that serves predominantly rural and frontier communities, as designated by the Office of Rural Health, and meets other criteria established by the Department of Human Services by rule.

(6) "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

(7) "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

(8) "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

(9) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

(10)(a) "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

(11) "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(12) "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

(13) "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the [*Oregon Health*] authority by rule.

(14) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

(15) "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

(16) "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

(17) "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

(18) "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period **in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013**.

(19) "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(20) "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

(21) "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

(22) "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

SECTION 17. ORS 442.315 is amended to read:

442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065**, and any long term care facility for which a license was surrendered under section 15 of this 2013 Act,** shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need. **The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.**

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.

SECTION 18. Section 18, chapter 736, Oregon Laws 2003, as amended by section 34, chapter 736, Oregon Laws 2003, section 7, chapter 757, Oregon Laws 2005, and section 10, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 18. [*(1)*] The Oregon Veterans' Home is exempt from the assessment imposed under section 16, chapter 736, Oregon Laws 2003.

[*(2) A waivered long term care facility is exempt from the long term care facility assessment imposed under section 16, chapter 736, Oregon Laws 2003.*]

[*(3) As used in this section, "waivered long term care facility" means:*]

[*(a) A long term care facility operated by a continuing care retirement community that is registered under ORS 101.030 and that admits:*]

[*(A) Residents of the continuing care retirement community; or*]

[*(B) Residents of the continuing care retirement community and nonresidents; or*]

[*(b) A long term care facility that is annually identified by the Department of Human Services as having a Medicaid recipient census that exceeds the census level established by the department for the year for which the facility is identified.*]

SECTION 19. Section 23, chapter 736, Oregon Laws 2003, as amended by section 8, chapter 757, Oregon Laws 2005, and section 11, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 23. Sections 15 to 22, chapter 736, Oregon Laws 2003, apply to long term care facility assessments imposed in calendar quarters beginning on or after November 26, 2003, and before July 1, [*2014*] **2020**.

SECTION 20. Section 24, chapter 736, Oregon Laws 2003, as amended by section 11, chapter 757, Oregon Laws 2005, and section 12, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 24. (1) The Long Term Care Facility Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Long Term Care Facility Quality Assurance Fund shall be credited to the fund.

(2) Amounts in the Long Term Care Facility Quality Assurance Fund are continuously appropriated to the Department of Human Services for the purposes of paying refunds due under section 20, chapter 736, Oregon Laws 2003, and funding long term care facilities, as defined in section 15,

chapter 736, Oregon Laws 2003, that are a part of the Oregon Medicaid reimbursement system.

(3) Funds in the Long Term Care Facility Quality Assurance Fund and the matching federal financial participation under Title XIX of the Social Security Act may be used to fund Medicaid-certified long term care facilities using only the reimbursement methodology described in [*subsection (4)*] **subsections (4) and (5)** of this section to achieve a rate of reimbursement greater than the rate in effect on June 30, 2003.

(4) The reimbursement methodology used to make additional payments to Medicaid-certified long term care facilities includes but is not limited to:

(a) Rebasing [*biennially, beginning on July 1 of each odd-numbered year*] **on July 1 of each year**;

[*(b) Adjusting for inflation in the nonrebasing year;*]

[*(c)*] **(b)** Continuing the use of the pediatric rate;

[*(d)*] **(c)** Continuing the use of the complex medical needs additional payment; **and**

[*(e)*] **(d)** Discontinuing the use of the relationship percentage, except when calculating the pediatric rate in paragraph [*(c)*] **(b)** of this subsection[*; and*]**.**

(5) In addition to the reimbursement methodology described in subsection (4) of this section, the department may make additional payments of $9.75 per resident who receives medical assistance to a long term care facility that purchased long term care bed capacity under section 15 of this 2013 Act on or after October 1, 2013, and on or before December 31, 2015. The payments may be made for a period of four years from the date of purchase. The department may not make additional payments under this section until the Medicaid-certified long term care facility is found by the department to meet quality standards adopted by the department by rule.

[*(f)*] **(6)(a)** [*Requiring*] The department [*of Human Services to*] **shall** reimburse costs **using the methodology described in subsections (4) and (5) of this section** at a rate not lower than [*the 63rd percentile ceiling*] **a percentile** of allowable costs for the [*biennium*] **period** for which the reimbursement is made.

(b) For the period beginning July 1, 2013, and ending June 30, 2016, the department shall reimburse costs at a rate not lower than the 63rd percentile of rebased allowable costs for that period.

(c) For each three-month period beginning on or after July 1, 2016, in which the reduction in bed capacity in Medicaid-certified long term care facilities is less than the goal established in section 15 of this 2013 Act, the department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 62nd percentile for a reduction of 1,350 or more beds.

(B) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(C) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(D) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(E) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(F) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(G) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(H) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(I) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(J) 53rd percentile for a reduction of 1 to 49 beds.

(7) A reduction in the percentile of allowable costs reimbursed under subsection (6) of

this section is not subject to ORS 410.555.

SECTION 21. Section 31, chapter 736, Oregon Laws 2003, as amended by section 9, chapter 757, Oregon Laws 2005, section 14, chapter 780, Oregon Laws 2007, and section 49, chapter 11, Oregon Laws 2009, is amended to read:

Sec. 31. Sections 15 to 22, 24 and 29, chapter 736, Oregon Laws 2003, are repealed on [*January 2, 2015*] **January 2, 2021**.

SECTION 22. ORS 442.015, as amended by section 16 of this 2013 Act, is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(3)(a) "Ambulatory surgical center" means a facility or portion of a facility that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

(b) "Ambulatory surgical center" does not mean:

(A) Individual or group practice offices of private physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a physician's or dentist's office using local anesthesia or conscious sedation; or

(B) A portion of a licensed hospital designated for outpatient surgical treatment.

(4) "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

[*(5) "Essential long term care facility" means an individual long term care facility that serves predominantly rural and frontier communities, as designated by the Office of Rural Health, and meets other criteria established by the Department of Human Services by rule.*]

[*(6)*] **(5)** "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

[*(7)*] **(6)** "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

[*(8)*] **(7)** "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

[*(9)*] **(8)** "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

[*(10)(a)*] **(9)(a)** "Health care facility" means:

(A) A hospital;

(B) A long term care facility;

(C) An ambulatory surgical center;

(D) A freestanding birthing center; or

(E) An outpatient renal dialysis center.

(b) "Health care facility" does not mean:

(A) A residential facility licensed by the Department of Human Services or the Oregon Health Authority under ORS 443.415;

(B) An establishment furnishing primarily domiciliary care as described in ORS 443.205;

(C) A residential facility licensed or approved under the rules of the Department of Corrections;

(D) Facilities established by ORS 430.335 for treatment of substance abuse disorders; or

(E) Community mental health programs or community developmental disabilities programs established under ORS 430.620.

[*(11)*] **(10)** "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

[*(12)*] **(11)** "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

[*(13)*] **(12)** "Hospital" means:

(a) A facility with an organized medical staff and a permanent building that is capable of providing 24-hour inpatient care to two or more individuals who have an illness or injury and that provides at least the following health services:

(A) Medical;

(B) Nursing;

(C) Laboratory;

(D) Pharmacy; and

(E) Dietary; or

(b) A special inpatient care facility as that term is defined by the authority by rule.

[*(14)*] **(13)** "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

[*(15)*] **(14)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental

or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(16)*] **(15)** "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director of Human Services, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(17)*] **(16)** "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(18)*] **(17)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period [*in a facility that applied for a certificate of need between August 1, 2011, and December 1, 2012, or submitted a letter of intent under ORS 442.315 (7) between January 15, 2013, and January 31, 2013*].

[*(19)*] **(18)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(20)*] **(19)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(21)*] **(20)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision or instrumentality, including a municipal corporation, of a state.

[*(22)*] **(21)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

SECTION 23. ORS 442.315, as amended by section 17 of this 2013 Act, is amended to read:

442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not excluded pursuant to ORS 441.065[*, and any long term care facility for which a license was surrendered under section 15 of this 2013 Act,*] shall obtain a certificate of need from the Oregon Health Authority prior to an offering or development.

(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.

(3)(a) An applicant for a certificate of need shall apply to the authority on forms provided for this purpose by authority rule.

(b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval of the Oregon Department of Administrative Services, the authority shall prescribe application fees, based on the complexity and scope of the proposed project.

(4) The authority shall be the decision-making authority for the purpose of certificates of need.

The authority may establish an expedited review process for an application for a certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term care facility or relocate long term care facility bed capacity from one long term care facility to another. The authority shall issue a proposed order not later than 120 days after the date a complete application for expedited review is received by the authority.

(5)(a) An applicant or any affected person who is dissatisfied with the proposed decision of the authority is entitled to an informal hearing in the course of review and before a final decision is rendered.

(b) Following a final decision being rendered by the authority, an applicant or any affected person may request a reconsideration hearing pursuant to ORS chapter 183.

(c) In any proceeding brought by an affected person or an applicant challenging an authority decision under this subsection, the authority shall follow procedures consistent with the provisions of ORS chapter 183 relating to a contested case.

(6) Once a certificate of need has been issued, it may not be revoked or rescinded unless it was acquired by fraud or deceit. However, if the authority finds that a person is offering or developing a project that is not within the scope of the certificate of need, the authority may limit the project as specified in the issued certificate of need or reconsider the application. A certificate of need is not transferable.

(7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service or facility that seeks to replace equipment with equipment of similar basic technological function or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with the rules of the authority if the price of the replacement equipment or upgrade exceeds $1 million.

(8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing or intermediate care service or facility not operating as a Medicare swing bed program, nothing in this section requires a rural hospital as defined in ORS 442.470 (5)(a)(A) and (B) to obtain a certificate of need.

(9) Nothing in this section applies to basic health services, but basic health services do not include:

(a) Magnetic resonance imaging scanners;

(b) Positron emission tomography scanners;

(c) Cardiac catheterization equipment;

(d) Megavoltage radiation therapy equipment;

(e) Extracorporeal shock wave lithotriptors;

(f) Neonatal intensive care;

(g) Burn care;

(h) Trauma care;

(i) Inpatient psychiatric services;

(j) Inpatient chemical dependency services;

(k) Inpatient rehabilitation services;

(L) Open heart surgery; or

(m) Organ transplant services.

(10) In addition to any other remedy provided by law, whenever it appears that any person is engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule or order issued by the authority under this section, the authority may institute proceedings in the

circuit courts to enforce obedience to such statute, rule or order by injunction or by other processes, mandatory or otherwise.

(11) As used in this section, "basic health services" means health services offered in or through a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing facilities or services and those services specified in subsection (9) of this section.

SECTION 24. Section 24, chapter 736, Oregon Laws 2003, as amended by section 11, chapter 757, Oregon Laws 2005, section 12, chapter 780, Oregon Laws 2007, and section 20 of this 2013 Act, is amended to read:

Sec. 24. (1) The Long Term Care Facility Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Long Term Care Facility Quality Assurance Fund shall be credited to the fund.

(2) Amounts in the Long Term Care Facility Quality Assurance Fund are continuously appropriated to the Department of Human Services for the purposes of paying refunds due under section 20, chapter 736, Oregon Laws 2003, and funding long term care facilities, as defined in section 15, chapter 736, Oregon Laws 2003, that are a part of the Oregon Medicaid reimbursement system.

(3) Funds in the Long Term Care Facility Quality Assurance Fund and the matching federal financial participation under Title XIX of the Social Security Act may be used to fund Medicaid-certified long term care facilities using only the reimbursement methodology described in [*subsections (4) and (5)*] **subsection (4)** of this section to achieve a rate of reimbursement greater than the rate in effect on June 30, 2003.

(4) The reimbursement methodology used to make additional payments to Medicaid-certified long term care facilities includes but is not limited to:

(a) Rebasing on July 1 of each year;

(b) Continuing the use of the pediatric rate;

(c) Continuing the use of the complex medical needs additional payment; and

(d) Discontinuing the use of the relationship percentage, except when calculating the pediatric rate in paragraph (b) of this subsection.

[*(5) In addition to the reimbursement methodology described in subsection (4) of this section, the department may make additional payments of $9.75 per resident who receives medical assistance to a long term care facility that purchased long term care bed capacity under section 15 of this 2013 Act on or after October 1, 2013, and on or before December 31, 2015. The payments may be made for a period of four years from the date of purchase. The department may not make additional payments under this section until the Medicaid-certified long term care facility is found by the department to meet quality standards adopted by the department by rule.*]

[*(6)(a)*] **(5)(a)** The department shall reimburse costs using the methodology described in [*subsections (4) and (5)*] **subsection (4)** of this section at a rate not lower than a percentile of allowable costs for the period for which the reimbursement is made.

(b) For the period beginning July 1, 2013, and ending June 30, 2016, the department shall reimburse costs at a rate not lower than the 63rd percentile of rebased allowable costs for that period.

(c) For each three-month period beginning on or after July 1, 2016, in which the reduction in bed capacity in Medicaid-certified long term care facilities is less than [*the goal established in section 15 of this 2013 Act*] **1,500 in bed capacity statewide that existed on the effective date of this 2013 Act**, the department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 62nd percentile for a reduction of 1,350 or more beds.

(B) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(C) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(D) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(E) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(F) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(G) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(H) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(I) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(J) 53rd percentile for a reduction of 1 to 149 beds.

[*(7)*] **(6)** A reduction in the percentile **ceiling** of allowable costs reimbursed under subsection [*(6)*] **(5)** of this section is not subject to ORS 410.555.

SECTION 25. (1) Section 1 of this 2013 Act and the amendments to ORS 414.746 and sections 2, 3, 6, 7, 8, 9, 10, 12 and 13, chapter 736, Oregon Laws 2003, by sections 2 to 11 of this 2013 Act become operative on the date that the Director of the Oregon Health Authority notifies the Legislative Counsel that the director received federal approval as described in section 13 of this 2013 Act.

(2) The repeal of ORS 414.746 by section 12 of this 2013 Act becomes operative April 1, 2014.

SECTION 26. (1) The amendments to section 18, chapter 736, Oregon Laws 2003, by section 18 of this 2013 Act become operative January 1, 2014.

(2) The amendments to ORS 442.015 and 442.315 and section 24, chapter 736, Oregon Laws 2003, by sections 22, 23 and 24 of this 2013 Act become operative June 30, 2020.

SECTION 27. Section 15 of this 2013 Act is repealed June 30, 2020.

SECTION 28. This 2013 Act takes effect on the 91st day after the date on which the 2013 regular session of the Seventy-seventh Legislative Assembly adjourns sine die.

February 1, 2012

<Oregon Tribal Representative>

<Address>

Dear XXXX:

The Oregon Health Authority (OHA) is in the process of developing two hospital payment proposals. These proposals originate from discussions between Oregon hospital representatives, OHA, and the Governor's Office in finalizing the Governor's 2013-15 Balanced Budget. Before implementing both proposals, the state will need to request federal approval from the Centers for Medicare and Medicaid Services (CMS) to amend the Oregon Health Plan (OHP) Medicaid demonstration waiver.

With our commitment to effective Tribal consultation and to comply with the CMS requirement to notify Tribes of anticipated Medicaid waiver amendments (as specified in State Medicaid Director's Letter #01-024 issued July 17, 2001), OHA is sharing information about these two hospital proposals to solicit your feedback.

Requested change

Although OHA is still refining the proposals, here is a general description of each program:

1. *Hospital Access to Care Fund Proposal*
   Under this proposal, OHA would establish an "Access to Care" fund or pool and make payments to diagnostic-related group (DRG) hospitals (i.e., large hospitals with 50 beds or more that accept reimbursement using Medicare's DRG payment methodology) to help ensure access to care for critical hospital services provided to Oregon's most vulnerable populations.
   - Payments would be based on their uncompensated care costs for serving Medicaid and uninsured individuals.

- To document uncompensated care costs, each DRG hospital would follow a uniform set of instructions to calculate their uncompensated care accordance with Medicare cost reporting principles.
- Hospital tax revenue would fund these payments.
- These new payments would replace hospital tax funded "hospital reimbursement adjustment" payments that DRG hospitals receive today from Coordinated Care Organizations (CCOs).

2. *Hospital Transformation Performance Program Proposal*
   Under this proposal, OHA would establish an incentive program using hospital tax revenue to allow DRG hospitals to earn payments by meeting performance goals during the 2013-15 biennium.
   - OHA, hospital representatives, and other key stakeholders would develop performance goals designed to advance health system transformation, reduce hospital costs, and improve patient safety.
   - The concept is to create a "win/win" for both hospitals and CCOs by reducing costs and quality.
   - Program payments would cover two years (July 1, 2013, through June 30, 2015).
   - Performance goals in the first year would focus on data submission. Performance goals in the second year would focus on improvement targets for quality and patient safety.

Impact on Tribal members

Although many program details are still under development for these proposals, OHA does not anticipate any immediate impact to Tribes or Tribal members who are on OHP. Over time, the *Hospital Transformation Performance Program* would hopefully improve the quality and coordination of care for all OHP clients needing hospital services.

Next steps

OHA is sharing these proposals with you to gather your comments and questions. I encourage you to comment and appreciate your advice.

OHA will accept written comments and questions through March 4, 2013. Please send your comments to: Janna Starr, Medical Assistance Programs, Oregon Health

Authority, 500 Summer St. NE, E-49, Salem, OR 97301-1079 or JannaStarr@state.or.us. If you have questions, please call Janna at 503-947-1193.

Sincerely,

Judy Mohr Peterson
Director, Division of Medical Assistance Programs
Oregon Health Authority

CC:
Terri Fraser, CMS, Baltimore
Gary Ashby, CMS, Region Office, Seattle
Bruce Goldberg, Director Department of Human Services

HOSPITAL ACCESS TO CARE PROGRAM
&
HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM

Medical Assistance Programs
Oregon Health Authority
State of Oregon
June 2013

The Oregon Health Authority (OHA) is providing this paper to provide more detailed information on the *Hospital Access to Care Program* and *Hospital Transformation Performance Program*, two proposals that the state is pursuing as amendments to the Oregon Health Plan Medicaid demonstration project. These proposals specifically apply to hospitals that pay an assessment on their net patient revenue.

Background

Since CMS's approval of Oregon's section 1115 Medicaid waiver amendment in July 2012, the Oregon Health Authority (OHA) has been working aggressively with Coordinated Care Organizations (CCOs) to provide high quality, high value, coordinated care to Oregon Health Plan (OHP) members. Fifteen CCOs have been formed in local communities across Oregon, serving more than 90 percent of Medicaid members, and include networks of all types of health care providers who have agreed to work together to slow the rate of health care spending while improving care.

Under Oregon's Triple Aim—better health, better care and lower costs—a substantial portion of the savings anticipated from CCOs' health care transformation will need to come from reduced utilization of hospital services. The Oregon Legislature just approved legislation that recognizes the contribution and role of hospitals in this process, as well as the transitioning of delivery methods that will be needed to achieve this outcome. House Bill 2216[1] extends the current hospital assessment through September 2015 and requires the OHA to pursue these two proposals—the *Hospital Access to Care Progra*m and the *Hospital Transformation Performance Program*—to assist hospitals in the transition. These proposals originate from discussions among Oregon hospital representatives, OHA and the Governor's Office in the development of the Governor's 2013-15 Balanced Budget.

The Oregon Legislature held several public hearings on House Bill 2216, allowing for public testimony and comment throughout the process. The Oregon House approved the bill on a 54-5 vote and the Oregon Senate approved it on a 25-5 vote. OHA has completed the required Tribal consultation regarding the proposals.

[1] House Bill 2216 is attached.

Hospital Access to Care Program

Issue/Problem:
Oregon designates larger, more urban hospitals as diagnostic-related group (DRG) hospitals. These hospitals receive reimbursement based on Medicare DRG payment methodology. The state designates smaller, more rural hospitals and critical access hospitals as Type A and Type B hospitals, which receive reimbursement fully for their costs of providing services to Medicaid and CHIP clients.

Oregon's DRG hospitals continue to absorb large amounts of uncompensated care for uninsured individuals and those covered by Medicaid and CHIP. Unlike Oregon's Type A and B hospitals, the DRG hospitals do not receive reimbursement fully for their costs. In addition, Oregon's disproportionate share hospital (DSH) allotment is substantially less than the actual uncompensated care costs relative to the inpatient and outpatient services provided to these patients. Oregon is designated by CMS as a "low DSH" state.

After January 2014, OHA anticipates there will continue to be uninsured individuals utilizing hospital services and creating uncompensated costs. Even for those individuals who are Medicaid and CHIP eligible, Medicaid and CHIP rates do not fully compensate DRG hospitals for the services they provide. Therefore, Oregon DRG hospitals will continue to experience uncompensated and undercompensated care costs after the anticipated Medicaid expansion under the Affordable Care Act.

Proposal/Solution:
Oregon proposes to establish a *Hospital Access to Care Program (HACP)* to partially reimburse DRG hospitals based on their share of uncompensated care costs[2]. OHA would calculate payments under this program according to each DRG hospitals relative share of uncompensated care costs. These payments would help ensure access to care for critical hospital services, and help CCOs manage appropriate treatment plans for its Oregon Health Plan clients.

The new HACP would replace the "hospital reimbursement adjustment" (HRA), which is a component built into the capitation rates paid to managed care organizations (MCOs), including Coordinated Care Organizations (CCOs). Currently, the MCOs/CCOs distribute the money they receive from the HRA to the DRG hospitals that provide services to their enrollees. Based on the pending legislation, OHA will be seeking to end the HRA and create the HACP as a new program in which the state pays the hospitals directly.

Funding of Hospital Access to Care Program:
The state share of these payments would continue to be funded by hospital assessment revenue.

[2] Uncompensated care costs refer to both costs for the treatment and services provided to the uninsured that are not paid by any party as well was the "under-compensated" costs, the portion of costs for Medicaid patients that remains unpaid.

House Bill 2216 extends the hospital assessment on Oregon's DRG hospitals for two more years, until 2015. The assessment is based on a percentage of net patient revenue, set and approved by the OHA Director. Hospital provider assessment revenues are considered "state funds", and thus, are eligible for federal government matching at the Federal Medical Assistance Percentage (FMAP) rate. These funds are then used by the state to fund the Oregon Health Plan programs.

Payments and Documentation:
To allocate the total dollars from the *Hospital Access to Care Program (HACP)*, OHA would make quarterly payments based on each DRG hospital's documented uncompensated hospital costs (i.e., inpatient and outpatient services) and uncompensated non-hospital costs (i.e., physician, other professional, pharmacy, provider-based clinic services) provided to Medicaid and uninsured individuals after all other Medicaid revenues and Medicaid disproportionate share hospital (DSH) payments have been accounted against such costs.[3]

For example, if there were 5 hospitals participating in HACP, with the following distribution of documented uncompensated care costs, and $350 million in HACP Total Funds annually, this is how the distribution for each hospital would be determined:

	Total Uncompensated Hospital and Non-Hospital Costs	Share of Total Uncompensated Hospital and Non-Hospital Costs (%)	Share of $350 Million HACP Total Funds (annual)
Hospital 1	$50 million	10%	$35 million
Hospital 2	$50 million	10%	$35 million
Hospital 3	$100 million	20%	$70 million
Hospital 4	$100 million	20%	$70 million
Hospital 5	$200 million	40%	$140 million
Total	**$500 million**	**100%**	**$350 million**

OHA would calculate the total dollars to be distributed through the HACP by determining the amount needed to meet the statutory requirement to pay DRG hospitals enhanced reimbursement. Current budget modeling projects approximately $350 million in Total Funds would be paid annually through the program.

To document each hospital's uncompensated care, OHA would:

- Provide each hospital a uniform set of instructions to follow to calculate their uncompensated care costs consistent with Medicare cost reporting principles.
- Include with these instructions a workbook that identifies costs on a cost-center-specific basis entirely consistent with the required cost calculations under the federal Medicaid DSH audit regulations.

[3] Oregon's DSH allotment is substantially less than the actual uncompensated care costs relative to the inpatient and outpatient hospital services provided to Medicaid and uninsured individuals.

- Furnish the workbook for each hospital to CMS upon request.

This precise documentation of costs would be derived from each hospital's Medicare cost reports from a state fiscal year base period. For the period of October 1, 2013, through September 30, 2014, OHA would use the information from each hospital's Medicare cost reports during state fiscal year 2011 (July 1, 2010 – June 30, 2011). To estimate the eligible uncompensated care costs for each subsequent payment year, OHA would require the base period to be moved forward by one year. Thus, for the period of October 1, 2014, through September 30, 2015, OHA would utilize information from each hospital's Medicare costs reports during state fiscal year 2012 (July 1, 2011 – June 30, 2012).

Based on the precise cost calculations, the required use of an updated base period to estimate eligible uncompensated care costs, and the substantial estimated uncompensated care shortfall that exists even after Hospital Access to Care Program payments are made, OHA would not reconcile the program payments.

Although the allocation methodology is based on uncompensated care, the HACP payments would not be direct payment for services, but would ensure DRG hospital are able to provide OHP clients access to care while recognizing their financial burden from serving vulnerable populations.

Hospital Transformation Performance Program

Issue/Problem:
DRG hospitals have invested heavily in developing state-of-the-art facilities and providing high-quality services with the best health care professionals they can attract. Each hospital or hospital system provides inpatient and outpatient services through its unique structure. Oregon's health care transformation is requiring hospitals, in conjunction with CCOs, to evaluate their care and business structures and pursue new and different paths to achieve the transformation goals of providing high quality care at the right time, in the right setting, and at lower costs. DRG hospitals have begun to implement delivery system changes, but need a transition period to make changes to their business models to successfully propel them forward in collaboration with the CCOs toward health system transformation.

Context:
Oregon's health care transformation via the Coordinated Care Organizations (CCOs) model calls for changes in the delivery system in many ways. Its success is premised on a partnership among those sharing in financial risk, providers of care, and community members. Collectively, the entire CCO team must change both the care model and the business model for the health system. By integrating and coordinating physical health, mental health, substance abuse, oral health, and long-term care services together, CCOs can institute changes that achieve the best possible outcomes for their membership. Hospitals have a significant role within the health system and—

to achieve these outcomes—their business models need to change. A substantial portion of savings from health system transformation is anticipated from reduced utilization of hospital services. In order for the overall CCO model and transformation efforts to be successful, increased focus and attention needs to be on the hospital portion of the delivery system.

Proposal/Solution:
Oregon proposes to establish the *Hospital Transformation Performance Program (HTPP)* to support and reward hospitals and hospital systems for improvements in their delivery systems that advance health system transformation, reduce hospital costs, and improve patient safety. Like the CCO quality incentive pool, these payments to hospitals are based on specific metrics, which are part of OHA's overall quality strategy and help track the performance of hospitals. The program directly supports health care transformation efforts by the CCOs and helps CCOs and Oregon meet state goals/objectives agreed to with CMS.

Based on the legislation, OHA would establish the HTPP to allow DRG hospitals to earn incentive payments by meeting specific performance objectives developed by a hospital performance metrics advisory committee appointed by the OHA Director. The committee would include four members who represent DRG hospitals, three who have expertise in measuring health outcomes, and two members who represent Coordinated Care Organizations. The advisory committee would be charged with recommending hospital-specific performance standards that are consistent with state and national quality standards and directly contribute to CCOs and the state's strategy for the Oregon Health Plan. Based on those recommendations, the OHA would adopt rules to establish the program, the performance standards, and the methodology for distributing the incentive payments. This is a similar process to the state's CCO quality incentive pool. The state would maintain direct responsibility for approving individual hospital plans, reviewing submissions of baseline and performance data, and authorizing the distribution of incentive funds. Overall, HTPP would be designed to complement and accelerate CCO activities and help CCOs achieve or accelerate improvements in patient care, quality of care, and reductions in the cost of care.

Funding and Payments:
Revenue from an additional one-percentage point increase in the hospital assessment rate would fund the HTPP. The increase in the assessment would provide the state share funding, approximately $166 million, to draw about $280 million in Medicaid match for the performance payments to qualifying DRG hospitals during the two-year period beginning October 1, 2013.

According to the legislation, OHA is required to distribute 50 percent of the two-year HTPP moneys in the first year of the program based upon each hospital's compliance with data submission requirements and 50 percent in the second year based on each hospital's achievement of the performance standards adopted by OHA. These payments are not duplicative of any other reimbursement currently provided to DRG hospitals.

It is important to note that the performance payments under this program would not be considered direct reimbursement for health care services provided by DRG hospitals. They would not be considered patient care revenue and would not be offset against disproportionate share expenditures or other Medicaid expenditures that are related to the cost of patient care.

Standard CMS Funding Questions

Specific to these two proposals, Oregon's responses to the standard CMS funding questions that are required with Medicaid State Plan Amendments would remain the same. The programs would be funded by revenue from the hospital assessment. The revenue generated by the assessment to fund the HRA would switch to funding the HACP payments. To fund the HTPP payments, OHA would increase the hospital assessment by one-percentage point, as directed in the legislation. The hospitals receiving these payments would retain 100% of the reimbursement from the state. No portion of the payments would be returned to the state.