

2011 LEGISLATIVE REPORTPrepared for ORHA
July 13, 2011**2011 SESSION SCORECARD**

Result	Issue	Bill #	Details
↑	Malpractice Subsidy	SB 608	Program fully funded with \$6.1 million. Funding in OHA budget (HB 5529).
↓	Loan Repayment	HB 2400	Request for \$3.1 million passed the House Health Committee and had a hearing in Ways and Means but was not funded in the final budget.
↑	Loan Forgiveness	HB 2397	Funded with \$525,000 to start a new program providing loans to students who are willing to commit to providing health care in rural communities.
↑	EMT MTU	HB 3580	Bill, asking for \$300,000 to fund one EMT Mobile Training Unit, passed House Health Committee. Ways and Means funded both MTUs in the Public Health budget using increased fees on medical marijuana cardholders.
↔	Type A & B Hospitals	HB 2377, SB 239 & HB 3650	SB 239, eliminating cost-based reimbursement for Type A & B hospitals that have a 5% profit margin, failed to move. Negotiations and amendments led to new language in the Health Care Transformation bill that will change Type A & B funding in the future.
↑	Health Care Transformation	HB 3650	New coordinated care organizations to coordinate physical, mental and dental health services to OHP. OHA is to develop CCO qualifications, global budget criteria and contract dispute process by February 2012.
↑	Insurance Exchange	SB 99	Legislators approved the framework for an Exchange and an Exchange Board. A detailed business plan will be developed for the February 2012 session.

SESSION SUMMARY

This was the most challenging budget session the legislature has faced in decades. And every one of ORHA's priority bills was a budget bill. Despite that, we did incredibly well. The Malpractice Subsidy program was continued with full funding. A new Loan Forgiveness program was created and funded. Funding for both of the EMT mobile training units was saved.

Our biggest setback was the continued lack of funding for the Loan Repayment program. We need to figure out if there will be any funding opportunities for programs like Loan Repayment in the February 2012 session. If not, we need to develop a new strategy for the 2013 session.

Although we beat back repeated efforts to cut funding for Type A & B hospitals, current cost-based reimbursement is only guaranteed through June 2014. We will need to work hard to make certain that rural hospital funding is protected after that.

As we look ahead to 2013, we already know that the rural health tax credit, which is scheduled to sunset, will be on the agenda along with funding for the malpractice subsidy, loan forgiveness, loan repayment and EMT MTUs.

ORHA PRIORITIES

RURAL MALPRACTICE SUBSIDY – SB 608

Passed

The Rural Malpractice Subsidy was fully funded for 18 months, from January 2012 through June 2013, with \$6.1 million. The program provides subsidies to physicians and nurse practitioners in rural areas, particularly those who practice obstetrics.

LOAN REPAYMENT – HB 2400

Failed

The House Health Committee approved the request for \$3.1 million for the loan repayment program. Testimony from rural physicians and medical school students made a compelling case about the need to offset medical school debt of up to \$200,000 to attract primary care providers to rural communities. The Education Subcommittee of Ways and Means also heard the bill, but ultimately it was not funded.

Efforts to gain some funding for the program in the end-of-session "Christmas tree bill" were also unsuccessful.

LOAN FORGIVENESS – HB 2397

Passed

This is one of the few new programs started and funded by the legislature in 2011. The loan forgiveness program, funded with \$525,000, will provide loans to students studying to be physicians, nurse practitioners or physician assistants who are committed to work in a rural area. Loans of up to \$35,000 per year, administered by the Office of Rural Health, will be awarded to students beginning in their second year of training. Each year of loan will be forgiven for a year spent practicing medicine in a rural Oregon community. Legislators liked the idea of rural communities being able to grow their own by identifying star students who want to become medical professionals.

EMT MTUs – HB 3850 & SB 5529

Funded

The legislature funded two EMT Mobile Training Units by doubling medical marijuana card fees — from \$100 to \$200 per year — that will raise \$7 million in 2011-13 to help fund public health. That funding was included in the public health budget.

ORHA and Rep. Jim Thompson (R-Dallas) requested \$300,000 for one EMT MTU in HB 3850, which passed the House Health Committee. One MTU was de-funded in the budget reductions in 2010. Without legislative action, funding for the other unit would have ended in July.

DENTAL THERAPIST PILOT PROJECTS – SB 738

Passed

The Oregon Oral Health Coalition wanted to create a new mid-level provider in dentistry, akin to a physician assistant in medicine. The dental therapist model, used in 53 countries plus Alaska and Minnesota, has proven effective at providing prevention and basic oral health services that are safe and affordable.

Although the idea had strong support from Sen. Laurie Monnes Anderson (D-Gresham), it also faced vehement opposition from the Oregon Dental Association (ODA). So at Sen. Monnes Anderson's request, the Oregon Oral Health Coalition (OrOHC) and the ODA entered into formal mediation.

Months of intense negotiations resulted in a consensus bill with three components:

1. Dental therapist pilot projects,
2. Expanded scope for LAP hygienists and a name change to Expanded Practice Dental Hygienists, and
3. Community Dental Health Worker pilot projects (an ODA priority).

The negotiations were difficult but once consensus was reached, the bill sailed along until it hit the full Ways and Means Committee and Sen. Fred Girod (R-Stayton) a dentist. Girod adamantly opposed the bill saying it implied that "any moron could practice dentistry."

Senate Republicans felt bad because they had not supported Girod on gillnetting legislation, so they decided to lock up in support of Girod on this issue. SB 738 was defeated in full Ways and Means. It took two procedural votes and President Courtney taking Sen. Betsy Johnson's place to revive the bill and move it out of committee.

The Senate passed it 16-14 on a straight party-line vote. After all the turmoil in the Senate, the bill passed easily, 50-5, in the House.

HEALTH CARE REFORM

COORDINATED CARE ORGANIZATIONS TO TRANSFORM OHP – HB 3650

Passed

Governor Kitzhaber proposed, and dozens of others helped shape, a new vision for delivering Medicaid in Oregon. Communities will be encouraged to form Coordinated Care Organizations (CCOs) to deliver physical and mental health services to those eligible for the Oregon Health Plan. Dental services must be added by 2014.

Kitzhaber says the plan "shifts the focus and financial incentives ... from expensive after-the-fact acute care to prevention, wellness and community-based management of chronic conditions."

Funding will be pooled in a global budget. The CCOs will be given flexibility to spend those dollars in the best way to keep people healthy. Much of the focus is expected to be on those with chronic illnesses.

As much as possible, the CCOs are required to use:

- Primary care homes,
- Payment methodologies other than fee for service, and
- Electronic medical records.

The Oregon Health Authority will be responsible for working out the details for implementation and bringing the plan back to the February 2012 session for approval. HB 3650 also requires OHA to report back on potential cost savings from a number of malpractice reform options including caps on damages for those acting as agents of the state and medical panels.

The state budget presumes \$240 million in general fund savings, more than \$700 million in total funds savings, in the second year of the biennium from these coordinated services. Most legislators and health care professionals don't believe savings that large can happen that quickly.

INSURANCE EXCHANGE – SB 99

Passed

Oregon plans to create an online Insurance Exchange to make it easier for individuals and small groups to comparison shop for health insurance based on cost and quality. The Exchange will also administer the federal subsidies to purchase insurance.

A nine-member board, appointed by the Governor and confirmed by the Senate, will oversee the Exchange. Rocky King was chosen as the interim Exchange Director until the board is created.

Ultimately, the House adopted the Senate version of the Insurance Exchange, which includes:

- Dual Markets – allowing carriers to sell insurance both inside and outside the Exchange,
- A Role for Agents – with payment to be determined by the Exchange Board,
- Defined Contribution Plans – employers may designate the amount available and let employees choose from any qualified plan,
- # of Plans – any plan that qualifies may be sold through the Exchange though the Exchange may limit the number of plans from each carrier, and
- Board Membership – up to two of the nine board members may have health care affiliations.

A coalition led by OSPIRG and SEIU opposed SB 99. They argued that no one with ties to the health care industry should be allowed on the board. They also wanted the Exchange to be able to negotiate rates and limit the number of plans available. The legislature rejected their proposal, though the issue about negotiating rates may come back in February.

Politically, it wasn't easy crafting an Exchange plan that would pass. Ultimately, the work done by Senators Frank Morse (R-Albany), Alan Bates (D-Ashland), Laurie Monnes Anderson (D-Gresham) and Jeff Kruse (R-Roseburg) was approved by the Senate and was unchanged in the House.

The Oregon Health Authority (OHA) will create a business plan for the Exchange that will come back to the legislature for approval in the February 2012 session. The Exchange must be set-up by January 2013 so that it can start enrollment and be active by January 2014.

During the session, Oregon accepted a \$48 million federal grant to develop the Exchange infrastructure.

HOSPITAL FUNDING

HOSPITAL TAX/OHP PROVIDER CUTS – SB 5529

The Governor's budget proposed reducing Oregon Health Plan (OHP) provider rates by 19% in the first year of the biennium. After negotiations with the hospital association, legislators agreed to use the hospital tax to lower the 19% reduction to 11.2% for all OHP providers including hospitals, physicians, dentists, Rx, and durable medical equipment.

The hospitals then agreed to an additional increase in the hospital tax to buy down the hospital rate cuts to 1.2%.

The Oregon Health Authority budget maintains cost-based reimbursement for Type A & B hospitals, but future funding for Type A & B hospitals could change based on language in the health care transformation bill (HB 3650).

Emergency Medical Services and the trauma system are restored by doubling the fees for medical marijuana users.

The OHA budget presumes \$240 million in General Fund savings from the health care transformation in the second year of the biennium. Adding in the federal matching funds, that means more than \$700 million must be saved in the transformation process or cut from provider reimbursement.

So, if the transformation savings don't materialize, hospitals are looking at rate cuts as high as 30% in the second year of the biennium. Rate cuts for other providers could be as high as 40%.

TYPE A & B HOSPITAL FUNDING – SB 239, HB 2377 & HB 3650

There were non-stop efforts throughout the session, by legislators and the managed care organizations represented by COHO, to take away cost-based reimbursement from rural hospitals.

COHO's bill, SB 239, was the most draconian. Under SB 239, if a Type B hospital showed a 5 percent profit in any one year, the hospital would lose cost-based reimbursement. It did not matter how many years of losses it had shown previously, and the bill had no mechanism for the hospital to regain cost-based reimbursement once lost. SB 239 was a recipe for hospital bankruptcy and closure that died in the Senate Health Committee.

HB 2377, another bill to cut rural hospital funding, never had a hearing in the House.

COHO kept up its attacks throughout the Transformation process. The hospital association finally amended HB 3650 to guarantee cost-based reimbursement for Type A and B hospitals through July 1, 2014. After that, the Oregon Health Authority will use an independent actuary to identify rural hospitals that would not be financially viable if they lost cost-based reimbursement.

MEDICARE METHODOLOGY & \$100 MILLION CUT FROM HOSPITALS – SB 204 *Passed*

SB 204 started out as a way to change hospitals' billing methodology in OHP. Starting in January 2012, hospitals would use Medicare methodology when billing for OHP (Type A & B hospitals are exempt). Ambulatory surgery centers would follow in 2013. Legislators believe this will result in long-term savings in the Oregon Health Plan.

But legislators decided to also use SB 204 as a mechanism to reduce hospital reimbursement in OHP on top of the already massive cuts proposed in the Governor's budget.

Initially, legislators proposed a \$50 million cut for hospitals. Hospitals balked at that, so legislators increased the cut to \$100 million.

The House Health Committee and both chambers pushed SB 204 through with virtually no discussion.

NON-PAR RATES – SB 101*Passed*

The hospital association and COHO compromised on new standards for those situations when managed care plans and hospitals cannot agree on contracts, i.e., non-participating or non-par providers.

The new agreement presumes good faith negotiations before new Medicaid rates go into effect September 1, 2011. In cases where an agreement isn't reached, the parties can agree to binding arbitration. If no agreement is reached, the managed care plans will pay 4% below Medicare. This is 2% less than the current rate.

ANTI-HOSPITAL BILLS**SB 202, 205, 209 & 578***Failed*

Democrats in the Senate Health Committee kept four of Sen. Alan Bates' (D-Ashland) anti-hospital bills alive by sending them to the Rules Committee, where they died.

SB 202 is a Certificate of Need bill

SB 205 adds a fair hearing process for physician hospital privileges

SB 209 deals with hospital CEO compensation

SB 578 adds state certification for hospital nonprofit status

HIT PRIVACY – HB 2224*Failed*

HB 2224 would have required hospital and insurance companies CEOs to certify each year that they've reviewed the privacy safeguard system for patient records and reported problems to their Boards of Directors. OAHHS was concerned a CEO could be held civilly responsible for a breach of HIT privacy if the bill were to pass. HB 2224 failed to move out of the House Health Committee after a tied vote.

NEVER EVENTS & SURGICAL CHECKLISTS – HB 2271 and SB 213

The Douglas County IPA and MVP Health Authority (formerly Mid Valley IPA) tried a last minute "gut and stuff" with SB 213 that would have changed a bill dealing with rural EMS providers to one prohibiting paying for "never events" and adverse events. SB 213 was not amended to include the never events gut and stuff and died in the Senate Health Committee.

Rep. Tina Kotek (D-Portland) and the Hospital Association agreed on amendments to HB 2271, which would have prevented facilities (including ambulatory surgery centers) from charging for adverse consequences. In a political move, House Republicans killed the bill in the House Health Committee.

The never events concept is included in the Transformation bill (HB 3650). That bill says a CCO will not pay if the service "is not covered by Medicare because it is related to a health care acquired condition."

TIGHTENING RULES ON CHARITABLE TAX DEDUCTIONS – SB 40*Failed*

SB 40, proposed by Attorney General John Kroger, would have disqualified tax-deductible charities spending more than 30 percent on administrative functions. OAHHS was concerned about whether the bill would apply to hospitals, which are not

the target of the bill but were not clearly stated in the exemptions. SB 40 died in the House Revenue Committee.

HOSPITAL COMMUNITY BENEFIT \$ FOR PUBLIC HEALTH – HB 2392 *Failed*

Rep. Tina Kotek (D-Portland) proposed mandating that 10 percent of hospitals' community benefit spending be used for "public health infrastructure," a term that was not defined. HB 2392 died in the House Health Committee.

PRIMARY CARE REIMBURSEMENT

OHP NEW RETIREMENT OPPORTUNITY – HB 3135 *Failed*

HB 3135, Rep. Ben Cannon's (D-Portland) bill that would have allowed OHP providers to contribute to the state's 457 retirement plan, failed to move out of the House Health Committee. Based on a model used in Mississippi, this issue is likely to resurface.

PRIMARY CARE PARITY PACKAGE – SB 850, SB 857 and SB 858 *Failed*

Sen. Chip Shields (D-Portland) introduced a package of bills to pay primary care providers more:

- SB 850 would require insurers to pay primary care providers higher reimbursement rates.
- SB 857 would give primary care providers legal rights to negotiate contractual changes with insurance companies.
- SB 858 would require insurers to pay nurse practitioners the same as physicians.

SB 850 and 857 failed to move out of the Senate Health Committee. SB 850 passed the Senate but died in the House Health Committee. We're likely to see these issues come back in future sessions.

OHP PRIMARY CARE REIMBURSEMENT – SB 210 *Failed*

SB 210, requiring OHP to pay primary care at 150% of the Medicare rate, passed the Senate Health Committee but died in Ways and Means. Introduced by Sen. Alan Bates (D-Ashland) and supported by COHO, the bill was designed to be revenue neutral, so it would have required managed care organizations to lower reimbursement to specialists or hospitals.

Sen. Bates has repeatedly stated that he will bring this issue back in future sessions.

FIVE-YEAR PLAN FOR INCREASING PRIMARY CARE \$ – HB 3246 *Failed*

Rep. Tina Kotek (D-Portland) introduced HB 3246, based on a Rhode Island model of requiring commercial health insurers to increase their expenditures on primary care by one percent each year for five years. The bill died in the House Health Committee.

REIMBURSING PSYCHIATRIC NPs – HB 3028 *Failed; Interim Workgroup*

HB 3028, requiring insurance companies to reimburse psychiatric mental health nurse practitioners, clinical nurse specialists and psychologists at the same rate as physicians when these providers use the same billing codes, failed to move out of the House Health Committee.

Legislators asked insurance carriers and nurse practitioners to work on it and bring it back in the February 2012 session.

CONTINUING MEDICAL EDUCATION

CULTURAL COMPETENCY – SB 97

Failed

Originally a cultural competency CE bill, SB 97 got watered down to a bill telling the Oregon Health Authority to develop culturally sensitive education materials and make them available to health care professionals who want them. SB 97 died twice on the House floor; each time, the vote was 30-30. Republicans argued it was going to cost a state agency money, so it should go to Ways and Means.

It is likely the proposal will come back in 2012.

BREAST EXAM – SB 493

Passed

SB 493, originally a CE bill, creates a taskforce to study when and how to improve breast exam continuing education, reporting back to the legislative assembly no later than the 2013 session.

SCOPE OF PRACTICE

PSYCHOLOGIST PRESCRIBING – HB 3523

Failed

For the third or fourth session in a row, psychologists tried to convince legislators that they should be allowed to prescribe psychotropic drugs. One of the most controversial issues in recent legislative sessions, the bill passed out of the House Health Committee and died in Ways and Means.

PA/NP Rx DISPENSING – SB 952 and HB 2386

Failed

Zoom Care, a Portland chain of clinics that provide low-cost primary and urgent care to uninsured and commercially insured patients, introduced two bills to expand physician dispensing to physician assistants and nurse practitioners. HB 2386 died in the House Health Committee. SB 952, which had the support of the OMA, ONA and Oregon Medical Board but was opposed by the National Association of Chain Drugstores and the Oregon State Pharmacy Association, passed out of the Senate Health Committee and died in Ways and Means. We'll likely see the issue again in future sessions.

BIRTH OUTCOMES – HB 3311

Passed

HB 3311 tasks the OHA with studying how doulas and community health workers can be used to help communities who face disproportionately greater risk of poor birth outcomes. The OHA will report its findings to the legislature in February 2012.

DIRECT-ENTRY MIDWIFES – HB 2380

Passed

Originally a bill that would have provided for a certification process for direct-entry midwives, HB 2380 now requires the Center for Health Statistics to collect and report data on all births and fetal deaths in Oregon. It also prohibits suing physicians or

hospitals for injuries to patients resulting from the care of a direct-entry midwife not at the hospital.

MEDICAL MALPRACTICE

EXPANDING OREGON'S APOLOGY LAW TO HOSPITALS – SB 95

Passed

SB 95 gives hospitals the same protections physicians currently have within Oregon's "apology" law, stipulating that an apology or statement of regret cannot be used as an admission of liability in medical malpractice cases.

Some hospitals have already adopted a philosophy of care that includes early disclosure and offer – when a mistake harms a patient, the hospital apologizes right away and makes a settlement offer.

MED MAL REFORMS – HB 3519, HB 3228 & HB 3650

There was optimism that this would be the session for tort reform. Republicans in the House and Senate said medical malpractice reform was a precondition for any substantive health care transformation.

Medical-legal screening panels are used in 19 other states. The panels would be managed by the state court system and funded by user fees. HB 3519 was thought to have a good chance of passage given the political makeup of the two chambers but it never moved out of the House Health Committee.

HB 3228 would have set a \$500,000 cap on noneconomic damages in claims against health providers. It, too, died in the House Health Committee.

Republicans insisted on some sort of malpractice reform in the health care transformation bill, HB 3650. Ultimately, they settled for a study by the Oregon Health Authority, that will look at potential savings from medical-legal panels, caps on damages, and award limits when providers are acting as agents of the state. That study is to be completed before the February 2012 session.

OTHER

RETAINER MEDICAL PRACTICES – SB 86

Passed

The Insurance Division introduced SB 86. They said a number of physicians had called their offices, wanting to offer prepaid primary care medical services, but did not want to run afoul of the insurance code. SB 86 was the Insurance Division's answer. It would allow doctors to sell prepaid services without an insurance license. The retainer practices would have to register with the Insurance Division, giving the division a better sense of how many retainer practices are out there and what types of services are they offering.

A number of doctors and nurse practitioners testified that this would be good for them and their patients. Some have high-end boutique practices; others sell a package of basic services to the uninsured or underinsured.

Legislators loved the idea of breaking the link between insurance and primary care; the idea that consumers could directly contract for basic preventive services. In many respects, it takes Oregon back to the early days of capitation.

SALES TAX FOR HEALTH CARE – SB 972

Failed

Portland lobbyist and attorney John DiLorenzo estimates a 5 to 7 percent constitutionally dedicated sales tax on goods and services (excluding groceries, shelter

and utilities) would be able to pay for an “essential” level of benefits for all eligible Oregonians. So he proposed SB 972, asking for a study of the issue, leading to a possible referral by the February 2012 session to the November 2012 ballot.

The idea has strong bipartisan support from the Senate Health Committee. Sen. Frank Morse (R-Albany) said, “We need to think thoughtfully about financing a system for health care that could really do something about cost and provide coverage for all eligible Oregonians.”

If the sales tax for health care passed, supporters say employers would no longer be expected to pay for employees’ basic health care. Also, supporters say no Oregonian would be subject to penalties under the Accountable Care Act for not purchasing health insurance.

Sen. Alan Bates (D-Ashland) said, “It’s a great plan; a great policy.” Committee members emphasized this is not a “single payer” plan, rather a “single funding, multiple payer system.”

Though the bill died in Ways and Means, after passing the Senate Health Committee, supporters are not giving up. DiLorenzo says he’s asking Gov. Kitzhaber to issue an Executive Order to have the Oregon Health Authority study the issue. So a sales tax plan may be on the February agenda after all.

ATTRACTING PRIMARY CARE PROVIDERS TO OREGON – HB 2366

Passed

HB 2366, introduced by Rep. Nancy Nathanson (D-Eugene), creates an interim workgroup to brainstorm ways in which Oregon can market itself to attract primary care providers.

CLINICAL ROTATION SIMPLIFICATION WORKGROUP – SB 879

Passed

This bill establishes a workgroup to look at ways to reduce the administrative burden and cost put on students and placement sites, including students’ background checks, drug screenings and immunizations that are needed for each training site. Supporters hope SB 879 will bolster Oregon’s rural healthcare workforce by reducing the hassle-factor for rural sites to accept student placements.

INSURANCE OVERPAYMENT RECOVERY – HB 2679

Passed

This changes the length of time an insurer has to recover overpayment on a billing from a physician or other health care provider from 24 months to 18 months. The 18-month limit also applies to providers seeking to collect underpayment from insurers. In addition, the bill amends the “timely filing” statute so providers could bill the appropriate insurer within 12 months after the denial of the claim or request for refund from the previous insurer.

The Oregon Medical Association (OMA), Ambulatory Surgery Centers and health insurers agreed to these new timelines. The bill passed in the closing days of the session.

“SILENT” PREFERRED PROVIDER ORGANIZATIONS – SB 634

Passed

SB 634 targets insurers that rent out provider networks to other insurers without seeking providers’ permission to do so. Insurers didn’t see the need for the bill, saying SB 634 was nearly identical to a 2009 bill that was the outcome of a workgroup that had difficulty coming to consensus on this issue.

PRIMARY CARE AND FIRST RESPONDERS

FAMILY MEDICINE RESIDENCY NETWORK – HB 2401

Passed

HB 2401 originally asked for \$1 million to help create a network for family medicine residency programs around the state to coordinate and work cooperatively. After indication from the House Health Committee that the bill would not be moved to Ways and Means, the funding was stripped from HB 2401 to make it a policy bill that encourages a cooperative family medicine residency network, facilitated by the Area Health Education Center at OHSU. The bill passed and became law on June 9, 2011.

PA LICENSING MODERNIZATION – SB 224

Passed

SB 224 modernizes the way physician assistants are licensed in Oregon. The bill de-links licensure from the practice agreement, allowing PAs to first get licensed, then find employment. The bill was a consensus bill between the OMA, Medical Board and the Oregon Society of Physician Assistants.

EMS – SB 234

SB 234 would have expanded the state's trauma system to include a regionalized stroke and heart attack response system. The Public Health Department asked for \$600,000 in 2011-13 and \$1 million the next biennium to do the work.

The hospital association was skeptical about this added expense when the current trauma system isn't fully funded and doesn't provide the level of response and feedback that hospitals expect.

Late session negotiations almost saved this bill. We expect work to continue during the interim and the bill to be brought back in February 2012.

The current trauma system was fully funded by Ways and Means.

In the closing days of the session, SB 234 was "gut and stuffed" with language from what had been HB 3667 that changes state EMS terminology to be consistent with national standards. For example, it changes Emergency Medical Technician to Emergency Medical Services Provider.

ORHA ONLINE BILL TRACKING: <http://mycm3.com/login.aspx?ReturnUrl=%2f>

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