Oregon Association of Hospitals and Health Systems

Legislative and Policy Update

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Agenda

- Political Landscape
- Policies Interest
  - Mergers & Acquisitions
  - Cost Growth Target
  - Public Option
  - Community Benefit Floor Spending

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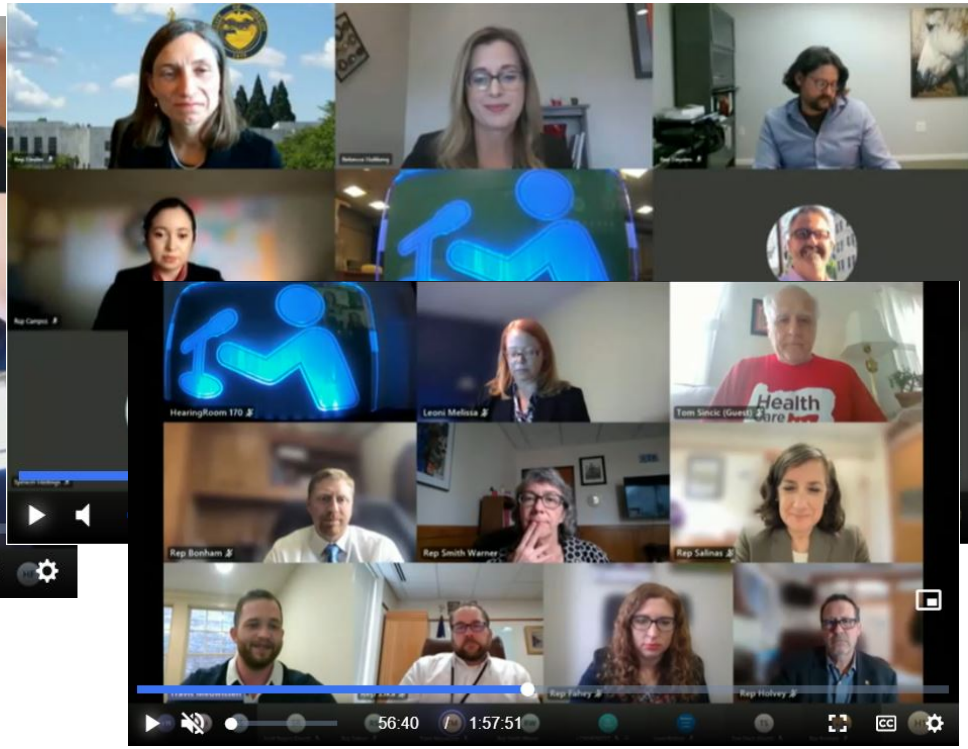
Political Landscape

Making policy in a virtual environment



2022 elections state of play

- House and Senate candidates will be running for new districts post redistricting
- First open Gubernatorial race since 2010
- Fallout of more polarized relationships
- Its an election year, politics will play a large role
  - What can they run on to display leadership/values?

Oregon Senate

Current: 18D/12R

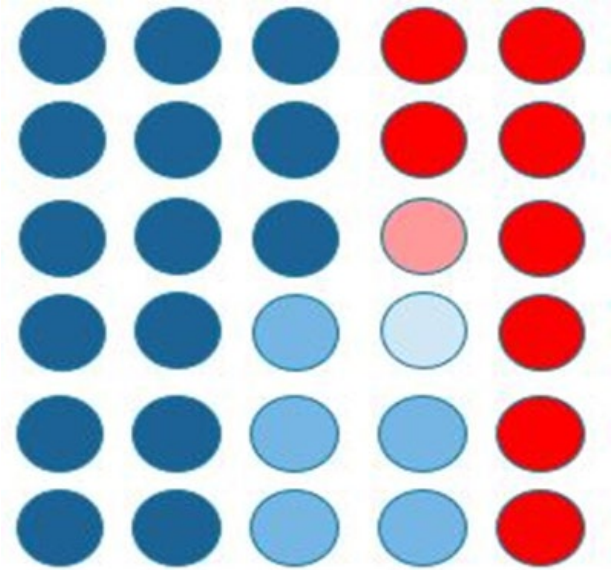
Safe R Seats: 8

Safe D Seats: 15

Competitive: 7

- Lean D: 5
- Lean R: 1
- Toss: 1

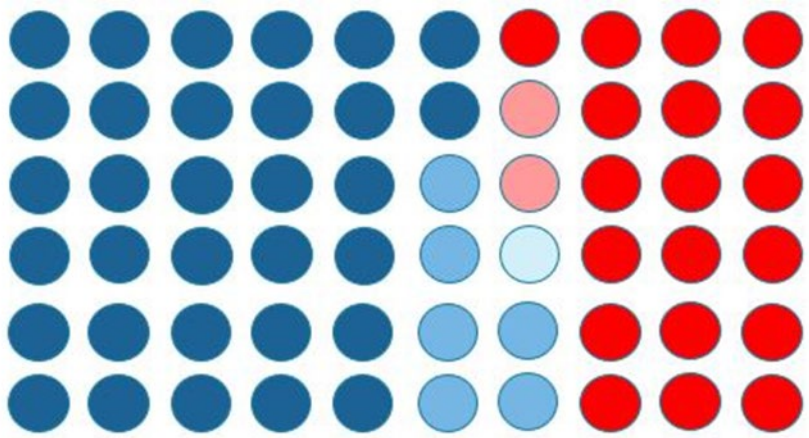
Possible 2023 Legislature: 21D:9R



*Competitiveness means the district has a registration equal or greater ratio of Democrats over Republicans in voter registration

Oregon House

Possible 2023 Legislature: 39D:21R



Current: 37D/23R

Safe R Seat: 19

Safe D Seat : 32

Competitive: 9

- Lean D: 6
- Lean R: 2
- Toss: 1

*Competitiveness means the district has a registration equal or greater ratio of six Democrats over Republicans in voter registration

Possible issues for 2022

- Focus on health care workforce
- Focus public health
- Continued COVID response
- Proposal on Public Option

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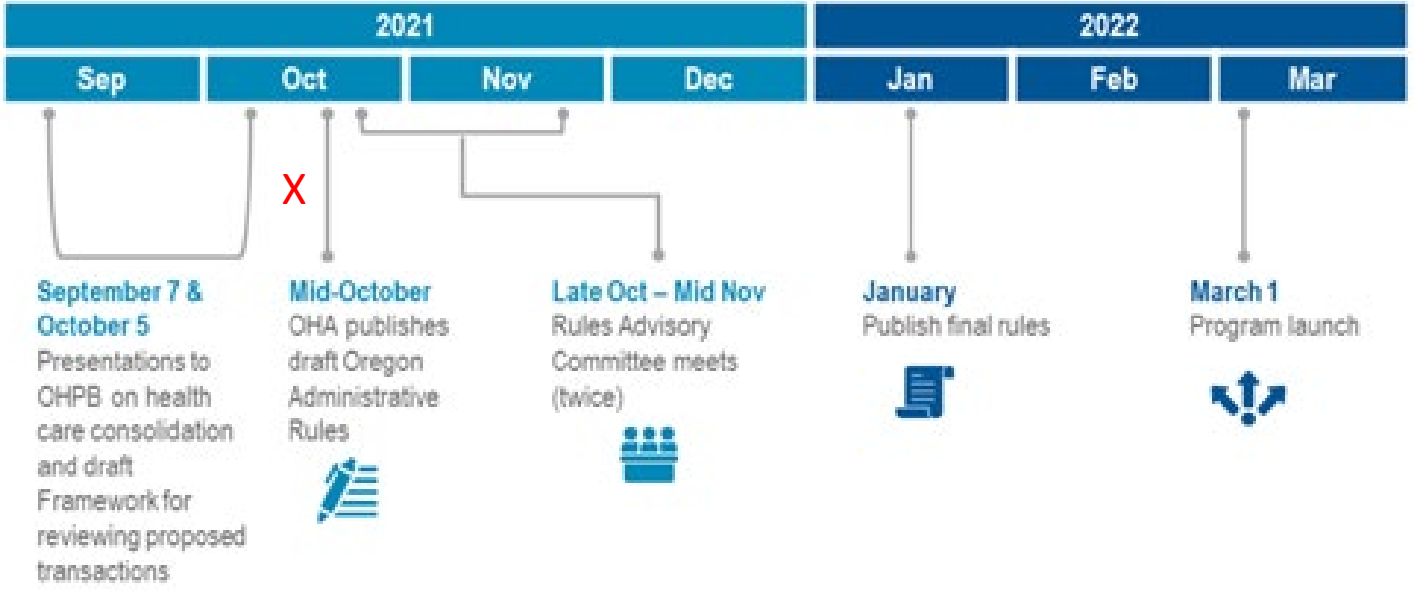
Policies of Interest

Health Care Market Oversight Program

- Establishes new responsibilities for OHA to review qualifying material change transactions such as mergers, acquisitions, and affiliations involving not only CCOs but also other health care entities such as health insurance companies, hospitals, provider organizations, and more.
- Charges OHA with reviewing the effects the material changes transaction
- Grants broad rule making authority

Health Care Market Oversight Program

Program Development Key dates



Objectives

- Avoid unnecessary cost and administrative complexity.
- Protect and advance the ongoing work across the state to achieve policy goals around the cost growth target, value-based payments, quality, and health equity by allowing transactions that further those goals to proceed without any disruption or delay.
- Ensure that the “emergency situation exemption” is applied to avoid delaying or prohibiting transactions that are necessary to preserve the availability of quality health care in a community.
- Incorporate frequent opportunities for communication and collaboration between OHA, the parties to the proposed transaction, and other reviewing agencies as applicable, to ensure transparency, efficiency, and the robust exchange of relevant data and information.
- Set forth standards and processes that are predictable and fair.

Initial letter to OHA

October XX, 2021

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Jeremy Vandehey, Health Policy & Analytics Division Director
Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301

Delivered electronically to hcmo.info@dhsoha.state.or.us.

Directors Allen and Vandehey,

On behalf of Oregon's 62 hospitals and the communities they serve, the Oregon Association of Hospitals and Health Systems (OAHHS) appreciates this opportunity to provide written feedback as an early step in the rulemaking process to implement House Bill 2362. OAHHS supports the goals of reducing cost and protecting and improving access to health care. We remain concerned that the process prescribed by HB 2362 will ultimately have the opposite effect. To prevent such an outcome, it is crucial that the implementing rules do the following:

- Avoid unnecessary cost and administrative complexity.
- Protect and advance the ongoing work across the state to achieve policy goals around the cost growth target, value-based payment, quality, and health equity by allowing transactions that further those goals to proceed without disruption or delay.
- Ensure that the "emergency situation exemption" is applied to avoid delaying or prohibiting transactions that are necessary to preserve the availability of quality health care in a community.
- Incorporate frequent opportunities for communication and collaboration between OHA, the parties to the proposed transaction, and other reviewing agencies as applicable, to ensure transparency, efficiency, and the robust exchange of relevant data and information.
- Set forth standards and processes that are predictable and fair.

Below, we provide specific recommendations for rulemaking to help achieve these objectives.

1. Define Terms

- Define "eliminate or significantly reduce essential services" to mean that access to a service within the service areas of the entities, taken as a whole and among all service

1. Define terms
2. Collaboration between agencies
3. Process for notice of a material change transaction
4. Reviews conducted
5. Comprehensive review and review board
6. Emergency situation exemption
7. Outline of processes
8. Other issues

Cost growth target legislation

- SB 889 (2019) – Established program and created Implementation Committee
- HB 2081 (2021) – Codifies enforcement provisions
  - Performance improvement plans
  - Financial penalties

Cost growth target program

- Establishes an annual per capital health care cost growth target to **3.4% for 2021-2025**
- Payer data submission is main source of data. Provider validation will occur before public reporting.

Reporting timeline

Calendar Year	2021	2022	2023	2024	2025	2026	2027
Measurement Period	Baseline: 2018-2020	Year 1: cost growth from 2020 to 2021	Year 2: cost growth from 2021 to 2022	Year 3: cost growth from 2022 to 2023	Year 4: cost growth from 2023 to 2024	Year 5: cost growth from 2024 to 2025	Year 6: cost growth from 2025 to 2026
Data Submission Date	10/01/2021	09/02/2022	09/01/2023	09/06/2024	09/05/2025	09/04/2026	09/03/2027
Payer / Provider Performance Identified in Public Reporting	No. Statewide and market level reporting only.	Yes	Yes	Yes	Yes	Yes	Yes
Accountability: PIPs	N/A	N/A	PIPs based on Year 2 performance	PIPs based on Year 3 performance	PIPs based on Year 4 performance	PIPs based on Year 5 performance	PIPs based on Year 6 performance
Accountability: Financial Penalties for payers or provider orgs who exceed the target in 3 out of 5 years	N/A	N/A	N/A	N/A	N/A	Escalating measures apply based on payers or provider orgs exceeding the target in Years 1-5	Escalating measures apply based on payers or provider orgs exceeding the target in Years 2-6

Cost growth target 2022+

- Implementation Committee disbands 12/2021
- New governance committee:
  - Cost Growth Target Advisory Committee
  - Subcommittee of the Oregon Health Policy Board

VBP voluntary compact

- As part of strategy to succeed under the 3.4% cost growth target, a group of 45+ payers and provider organizations have come together under a **voluntary compact** to **advance value-based payment models**

VBP workgroup

- Sponsored by the Oregon Health Leadership Council and Oregon Health Authority
- Workgroup deliverables:
  - VBP roadmap
  - Evaluation framework
  - Recommendations to address barriers
  - Annual public report

Public option

- HB 2010 requires OHA and DCBS to create an implementation plan for a public option health plan by January 1, 2022
- Similar legislation has passed in other states and is being considered at the federal level, but only WA has launched
- Likely to be a private carrier model – same as WA, CO, NV

Summary Comparison of Select Public Option Proposals

	Washington – Original Passed 2019 (SB 5526)	Washington – Updated Passed 2021 (SB 5377)	Colorado – Recommended to Legislature 2019	Colorado – Passed 2021 (HB21-1232)	Nevada – Passed 2021 (SB 420)	Federal Medicare-X Choice Act – Proposed 2019, 2021	Oregon – Proposed 2021 (HB 2010 as introduced)
Availability	Individual market on state exchange	Individual market on state exchange	Individual market, on and off state exchange; expand to small group	Individual and small group markets; on and off state exchange	Individual market on and off state exchange; option to offer to small group	Individual and small group exchanges, phased rollout	Individual and small group federal exchange; transition to state exchange
Premium Cost Targets	None required; provider rate cap waiver with 10% premium reduction	None required; provider rate cap waiver with 10% premium reduction	None required; raise medical loss ratio from 80% to 85%	15% over 3 years; hearing triggered if not met	15% over 4 years	None	None
Plan Participation	Not required	Not required, but state directed to contract with at least one plan in each county	Required if offering other plans on individual market	Required in counties where individual and small group plans are available	Not required, but Medicaid carriers must participate in bidding process	CMS	Required if currently contracted with PEBB/OEBB, Medicare Advantage, or CCO
Hospital Payment Rates	160% Medicare aggregate cap (excl. pharm); minimum 101% rural hospitals	160% Medicare aggregate cap (excl. pharm); minimum 101% rural hospitals	Set per hospital as % Medicare based on list of considerations	Minimum 155% Medicare; more for certain types of hospitals	Minimum 100% Medicare in aggregate	100% Medicare; up to 150% in rural areas	100% Medicare cap unless insufficient to attain network adequacy
Hospital Participation	Not required	Required if networks not adequate to offer plan in each county in 2022	Not required unless participation is needed for network adequacy	Not required until a hearing demonstrates necessity based on network adequacy and premiums	Required if participating in Medicaid, Work Comp, or Public Employee Benefits Program	Required if participating in Medicare or Medicaid	Required if participating in PEBB/OEBB, Medicare Advantage, or CCO
Monitoring	Implementation report	Hospital finance analysis after 10,000 enrolled; plans must provide quality data	Advisory board	Contract with independent third party to report on implementation	None	Grants program	Data collection by DCBS and OHA – enrollment, quality, competition, reimbursement rates

CB Minimum Spending Floor

Background

- With passage of HB 3076 in 2019, the Oregon State Legislature created a community benefit minimum spending floor program for Oregon's 60 acute care hospitals and their affiliated clinics.

- The bill allows hospitals to choose the grouping the spending floor is applied to, including but not limited to:
  - Each individual hospital and all the hospital's nonprofit affiliated clinics
  - A hospital and a group of the hospital's nonprofit affiliated clinics
  - All the hospitals that are under common ownership and control and all of the hospitals' nonprofit affiliated clinics
- OHA is required to apply the spending floor every two years, and calculates the spending floor for each year, two years at a time.

- The first spending floors apply to hospitals' fiscal years 2022 and 2023.

CB Minimum Spending Floor

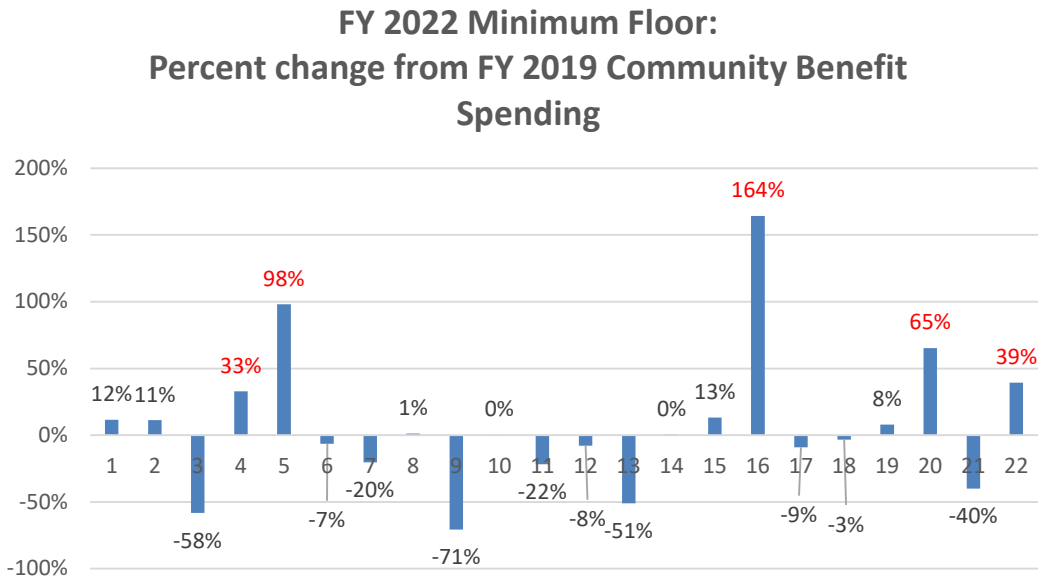
Status

- OHA has completed this calculation for 32 hospitals (22 entities) to date

Asante
Bay Area Hospital
Blue Mountain Hospital
Coquille Valley Hospital
Curry General Hospital
Good Shepherd Medical Center
Harney District Hospital
Hillsboro Medical Center
Lake District Hospital
Legacy
Lower Umpqua Hospital
Mercy Medical Center
Oregon Health & Science University Hospital
PeaceHealth
Pioneer Memorial Hospital
St. Alphonsus Medical Center – Baker City
St. Alphonsus Medical Center – Ontario
Salem Health
Sky Lakes Medical Center
Southern Coos Hospital & Health Center
St. Anthony Hospital
Wallowa Memorial Hospital

CB Minimum Spending Floor

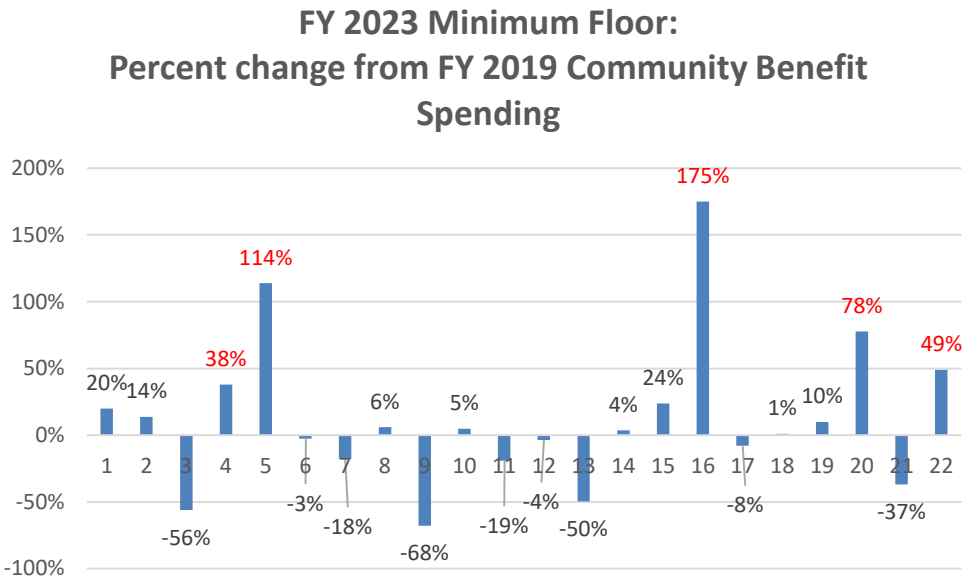
Quick Analysis



- Of the 22 entities, about half (10) needs to increase their spending to meet the minimum floor, and about half (12) already met
- Note that the increases needed can be quite high in some cases (in red)

CB Minimum Spending Floor

Quick Analysis



- Similar to FY 2022 minimum floor,13 entities need to increase their spending to meet the minimum floor.
- You should apply these minimum floor comparison to FY 2020 Community Benefit spending – which you already have; not public yet

CB Minimum Spending Floor

Action

- Review your spending floor calculations from the OHA
- Can request for Financial Hardship Waiver of a portion of the spending floor obligation
- There is also an opportunity for spending floor modification – a COVID-19-related Six-Month Check-in deadline, so **make sure you don't miss that if needed**
- Community Benefit Reporting is required, but there is currently no penalty for missing the minimum spending floor

Asante
Bay Area Hospital
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Coquille Valley Hospital
Curry General Hospital
Good Shepherd Medical Center
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Hillsboro Medical Center
Lake District Hospital
Legacy
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PeaceHealth
Pioneer Memorial Hospital
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St. Alphonsus Medical Center – Ontario
Salem Health
Sky Lakes Medical Center
Southern Coos Hospital & Health Center
St. Anthony Hospital
Wallowa Memorial Hospital

CB Minimum Spending Floor

Action

- Many hospital costs associated with the COVID-19 response can count toward the community benefit spending floor, typically in the categories of Community Health Improvement Services or Cash and In-Kind Contributions

- Examples of COVID-19-related community benefit investments:
  - Personal protective equipment (PPE) – Hospitals may count PPE provided to community organizations or groups or used in vaccination clinics, drive-up testing sites, or other public events
  - COVID testing sites – Hospitals may count expenses related to operating a public COVID-19 testing site if the facility did not require admission to the hospital or treatment by the hospital as a condition of testing
  - Vaccination sites - Hospitals may count expenses related to providing COVID-19 vaccines if the site was open to the general public or the priority groups specified by OHA

- All information about the program, methodology, data and calculations, and results for each hospital can be found at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx; scroll down to community benefit minimum spending floor

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Questions?

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