

SENATE AMENDMENTS TO SENATE BILL 1580

By JOINT COMMITTEE ON WAYS AND MEANS

February 10

1 On page 1 of the printed bill, line 2, after “414.033,” insert “414.065, 414.625,” and after
2 “414.635,” insert “414.638,”.

3 In line 3, delete “and 416.540” and insert “, 416.540 and 646.735”.

4 On page 2, line 8, delete “414.625 (1)(g)” and insert “414.625 (2)(g)”.

5 On page 3, line 23, delete “maintain the process” and before “for” insert “adopt by rule a pro-
6 cess”.

7 On page 4, after line 15, insert:

8 “(3) A plan or organization may establish an internal review process for a provider aggrieved
9 under this section, including an alternative dispute resolution or peer review process. An aggrieved
10 provider may appeal the determination of the internal review to the Oregon Health Authority.

11 “(4) The authority shall adopt by rule a process for resolving claims of discrimination under this
12 section and, in making a determination of whether there has been discrimination, must consider the
13 plan’s or organization’s:

14 “(a) Network adequacy;

15 “(b) Provider types and qualifications;

16 “(c) Provider disciplines; and

17 “(d) Provider reimbursement rates.

18 “(5) A prevailing party in an appeal under this section shall be awarded the costs of the
19 appeal.”.

20 Delete lines 16 through 30 and insert:

21 “**SECTION 9.** Section 8 of this 2012 Act is amended to read:

22 “**Sec. 8.** (1) A [*fully capitated health plan, physician care organization or*] coordinated care or-
23 ganization may not discriminate in the participation or reimbursement of any health care provider
24 based on the provider’s license or certification if the provider is acting within the scope of the
25 provider’s license or certification. [*A plan or*] **An** organization must give written notice containing
26 the reasons for its action if the [*plan or*] organization declines the participation of any provider or
27 group of providers.

28 “(2) Subsection (1) of this section does not:

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

31 “(b) Preclude the [*plan or*] organization from using different reimbursement amounts for different
32 specialties or different practitioners in the same specialty; or

33 “(c) Preclude the [*plan or*] organization from establishing measures that are designed to main-
34 tain the quality of services and control costs and are consistent with the [*plan’s or*] organization’s
35 responsibilities to its members.

1 “(3) [A *plan or*] **An** organization may establish an internal review process for a provider
2 aggrieved under this section, including an alternative dispute resolution or peer review process. An
3 aggrieved provider may appeal the determination of the internal review to the Oregon Health Au-
4 thority.

5 “(4) The authority shall adopt by rule a process for resolving claims of discrimination under this
6 section and, in making a determination of whether there has been discrimination, must consider the
7 [*plan’s or*] organization’s:

8 “(a) Network adequacy;

9 “(b) Provider types and qualifications;

10 “(c) Provider disciplines; and

11 “(d) Provider reimbursement rates.

12 “(5) A prevailing party in an appeal under this section shall be awarded the costs of the
13 appeal.”.

14 Delete lines 33 through 35 and insert:

15 **“SECTION 11. In each calendar quarter, the Oregon Health Authority shall report to the
16 appropriate committees or interim committees of the Legislative Assembly:**

17 **“(1) On the implementation of the Oregon Integrated and Coordinated Care Delivery
18 System;**

19 **“(2) On the progress in implementing an arbitration process in accordance with ORS
20 414.635 (7);**

21 **“(3) For the purpose of developing a baseline with which to compare future costs, per
22 member costs for each category of service; and**

23 **“(4) The administrative costs to the authority in the implementation of the system and
24 the aggregate financial information reported to the authority by coordinated care organiza-
25 tions, including but not limited to the coordinated care organizations’:**

26 **“(a) Payments for each category of service as prescribed by the authority; and**

27 **“(b) Reserves, projected cash flows and other financial information prescribed by the
28 authority by rule.”.**

29 After line 36, insert:

30 **“SECTION 13. (1) A coordinated care organization must have a community advisory
31 council to ensure that the health care needs of the consumers and the community are being
32 addressed. The council must:**

33 **“(a) Include representatives of the community and of each county government served by
34 the coordinated care organization, but consumer representatives must constitute a majority
35 of the membership;**

36 **“(b) Meet no less frequently than once every three months; and**

37 **“(c) Have its membership selected by a committee composed of equal numbers of county
38 representatives from each county served by the coordinated care organization and members
39 of the governing body of the coordinated care organization.**

40 **“(2) The duties of the council include, but are not limited to:**

41 **“(a) Identifying and advocating for preventive care practices to be utilized by the coor-
42 dinated care organization;**

43 **“(b) Overseeing a community health assessment and adopting a community health im-
44 provement plan to serve as a strategic population health and health care system service plan
45 for the community served by the coordinated care organization; and**

1 “(c) Annually publishing a report on the progress of the community health improvement
2 plan.

3 “(3) The community health improvement plan adopted by the council should describe the
4 scope of the activities, services and responsibilities that the coordinated care organization
5 will consider upon implementation of the plan. The activities, services and responsibilities
6 defined in the plan may include, but are not limited to:

7 “(a) Analysis and development of public and private resources, capacities and metrics
8 based on ongoing community health assessment activities and population health priorities;

9 “(b) Health policy;

10 “(c) System design;

11 “(d) Outcome and quality improvement;

12 “(e) Integration of service delivery; and

13 “(f) Workforce development.

14 “SECTION 14. (1) Upon the request of a coordinated care organization, the Oregon Health
15 Authority shall assign to the coordinated care organization one employee of the authority,
16 called an innovator agent, to act as the single point of contact between the coordinated care
17 organization and the authority. The innovator agent must be available to the organization
18 on a day-to-day basis to facilitate the exchange of information between the coordinated care
19 organization and the authority. The organization may provide a work space to enable the
20 agent to be colocated at a site of the coordinated care organization if practical.

21 “(2) Innovator agents must observe the meetings of the community advisory councils and
22 report on the meetings to the authority.

23 “(3) Not less than once every calendar quarter, all of the innovator agents must meet in
24 person to discuss the ideas, projects and creative innovations planned or undertaken by their
25 assigned coordinated care organizations.

26 “(4) The innovator agent shall be made available by the authority for a period of four
27 years beginning on the date that the coordinated care organization first contracts with the
28 authority to be a coordinated care organization. Upon the request of the coordinated care
29 organization, the authority may extend the period.

30 “SECTION 15. Section 16 of this 2012 Act is added to and made a part of ORS 192.553 to
31 192.581.

32 “SECTION 16. (1) Notwithstanding ORS 179.505, a health care provider that is a partic-
33 ipant in a coordinated care organization, as defined in ORS 414.025, shall disclose protected
34 health information:

35 “(a) To other health care providers participating in the coordinated care organization for
36 treatment purposes, and to the coordinated care organization for health care operations and
37 payment purposes, as permitted by ORS 192.558; and

38 “(b) To public health entities as required for health oversight purposes.

39 “(2) The disclosures described in subsection (1) of this section may be provided without
40 the authorization of the patient or the patient’s personal representative.

41 “(3) Subsection (1) of this section does not apply to psychotherapy notes, as defined in
42 ORS 179.505.

43 “SECTION 17. (1) The work group on Patient Safety and Defensive Medicine is estab-
44 lished, consisting of eight members appointed as follows:

45 “(a) The President of the Senate shall appoint two members from among members of the

1 Senate as follows:

2 “(A) One member from the Democratic party.

3 “(B) One member recommended by the leadership of the Republican party in the Senate.

4 “(b) Each Co-Speaker of the House of Representatives shall appoint one member from
5 among members of the House of Representatives.

6 “(c) The Governor shall appoint four members, including:

7 “(A) At least one member who is a physician licensed under ORS chapter 677 and in ac-
8 tive practice; and

9 “(B) At least one member who is a trial lawyer.

10 “(2) Under the direction of the Governor, the work group shall recommend legislation to
11 be introduced in the 2013 regular session of the Legislative Assembly to improve health care
12 delivery in this state and to reduce medical errors. The work group shall prioritize legislation
13 that:

14 “(a) Improves patient safety;

15 “(b) More effectively compensates individuals who are injured as a result of medical er-
16 rors; and

17 “(c) Reduces the collateral costs associated with the medical liability system, including
18 the costs associated with insurance administration, litigation and defensive medicine.

19 “(3) A majority of the voting members of the work group constitutes a quorum for the
20 transaction of business.

21 “(4) Official action by the work group requires the approval of a majority of the voting
22 members of the work group.

23 “(5) The Governor shall select one member of the work group to serve as chairperson
24 and another to serve as vice chairperson, for the terms and with the duties and powers
25 necessary for the performance of the functions of such offices as the Governor determines.

26 “(6) If there is a vacancy for any cause, the appointing authority shall make an appoint-
27 ment to become immediately effective.

28 “(7) Members of the Legislative Assembly appointed to the work group are nonvoting
29 members of the work group and may act in an advisory capacity only.

30 “(8) The work group shall meet at times and places specified by the call of the chair-
31 person or of a majority of the voting members of the work group.

32 “(9) The work group may adopt rules necessary for the operation of the work group.

33 “(10) The work group shall submit its recommendations for legislation to the interim
34 committees of the Legislative Assembly related to health care no later than October 1, 2012.

35 “(11) The Oregon Health Authority shall provide staff support to the work group.

36 “(12) Members of the work group who are not members of the Legislative Assembly are
37 not entitled to compensation, but may be reimbursed for actual and necessary travel and
38 other expenses incurred by them in the performance of their official duties in the manner
39 and amounts provided for in ORS 292.495. Claims for expenses incurred in performing func-
40 tions of the work group shall be paid out of funds appropriated to Oregon Health Authority
41 for purposes of the work group.

42 “(13) All agencies of state government, as defined in ORS 174.111, are directed to assist
43 the work group in the performance of its duties and, to the extent permitted by laws relating
44 to confidentiality, to furnish such information and advice as the members of the work group
45 consider necessary to perform their duties.

1 “**SECTION 18. Section 17 of this 2012 Act is repealed on the date of the convening of the**
2 **2013 regular session of the Legislative Assembly as specified in ORS 171.010.**

3 “**SECTION 19.** ORS 414.065 is amended to read:

4 “414.065. (1)(a) With respect to health care and services to be provided in medical assistance
5 during any period, the Oregon Health Authority shall determine, subject to such revisions as it may
6 make from time to time and subject to legislative funding and paragraph (b) of this subsection:

7 “(A) The types and extent of health care and services to be provided to each eligible group of
8 recipients of medical assistance.

9 “(B) Standards, including outcome and quality measures, to be observed in the provision of
10 health care and services.

11 “(C) The number of days of health care and services toward the cost of which public assistance
12 funds will be expended in the care of any person.

13 “(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing
14 health services to an applicant or recipient.

15 “(E) Reasonable fees for professional medical and dental services which may be based on usual
16 and customary fees in the locality for similar services.

17 “(F) The amount and application of any copayment or other similar cost-sharing payment that
18 the authority may require a recipient to pay toward the cost of health care or services.

19 “(b) The authority shall adopt rules establishing timelines for payment of health services under
20 paragraph (a) of this subsection.

21 “(2) The types and extent of health care and services and the amounts to be paid in meeting the
22 costs thereof, as determined and fixed by the authority and within the limits of funds available
23 therefor, shall be the total available for medical assistance and payments for such medical assistance
24 shall be the total amounts from public assistance funds available to providers of health care and
25 services in meeting the costs thereof.

26 “(3) Except for payments under a cost-sharing plan, payments made by the authority for medical
27 assistance shall constitute payment in full for all health care and services for which such payments
28 of medical assistance were made.

29 “(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services
30 shall be responsible for determining the payment for Medicaid-funded long term care services and
31 for contracting with the providers of long term care services.

32 “**(5) In determining a global budget for a coordinated care organization:**

33 “**(a) The allocation of the payment, the risk and any cost savings shall be determined by**
34 **the governing body of the organization; and**

35 “**(b) The authority shall consider the community health assessment conducted by the**
36 **organization and reviewed annually, and the organization’s health care costs.**

37 “**(6) Under the supervision of the Governor, the authority may work with the Centers for**
38 **Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:**

39 “**(a) To support improved delivery of health care to recipients of medical assistance; and**

40 “**(b) That are funded by coordinated care organizations, counties or other entities other**
41 **than the state whose contributions qualify for federal matching funds under Title XIX or**
42 **XXI of the Social Security Act.**

43 “**SECTION 20.** ORS 414.625 is amended to read:

44 “414.625. (1) The Oregon Health Authority shall adopt by rule the **qualification criteria and**
45 **requirements** for a coordinated care organization and shall integrate the criteria **and require-**

1 **ments** into each contract with a coordinated care organization. Coordinated care organizations may
2 be local, community-based organizations or statewide organizations with community-based partic-
3 ipation in governance or any combination of the two. Coordinated care organizations may contract
4 with counties or with other public or private entities to provide services to members. The authority
5 may not contract with only one statewide organization. A coordinated care organization may be a
6 single corporate structure or a network of providers organized through contractual relationships.
7 The criteria adopted by the authority under this section must *[be designed]* **include, but are not**
8 **limited to, the coordinated care organization’s demonstrated experience and capacity for:**

9 “(a) **Managing financial risk and establishing financial reserves.**

10 “(b) **Meeting the following minimum financial requirements:**

11 “(A) **Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the**
12 **coordinated care organization’s total actual or projected liabilities above \$250,000.**

13 “(B) **Maintaining a net worth in an amount equal to at least five percent of the average**
14 **combined revenue in the prior two quarters of the participating health care entities.**

15 “(c) **Operating within a fixed global budget.**

16 “(d) **Developing and implementing alternative payment methodologies that are based on**
17 **health care quality and improved health outcomes.**

18 “(e) **Coordinating the delivery of physical health care, mental health and chemical de-**
19 **pendency services, oral health care and covered long-term care services.**

20 “(f) **Engaging community members and health care providers in improving the health of**
21 **the community and addressing regional, cultural, socioeconomic and racial disparities in**
22 **health care that exist among the coordinated care organization’s members and in the coor-**
23 **dated care organization’s community.**

24 “(2) **In addition to the criteria specified in subsection (1) of this section, the authority**
25 **must adopt by rule requirements for coordinated care organizations contracting with the**
26 **authority so that:**

27 “(a) Each member of the coordinated care organization receives integrated person centered care
28 and services designed to provide choice, independence and dignity.

29 “(b) Each member has a consistent and stable relationship with a care team that is responsible
30 for comprehensive care management and service delivery.

31 “(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
32 using patient centered primary care homes **or other models that support patient centered pri-**
33 **mary care** and individualized care plans to the extent feasible.

34 “(d) Members receive comprehensive transitional care, including appropriate follow-up, when
35 entering and leaving an acute care facility or a long term care setting.

36 “(e) Members receive assistance in navigating the health care delivery system and in accessing
37 community and social support services and statewide resources, including through the use of certi-
38 fied health care interpreters, as defined in ORS 413.550, community health workers and personal
39 health navigators who meet competency standards established by the authority under ORS 414.665
40 or who are certified by the Home Care Commission under ORS 410.604.

41 “(f) Services and supports are geographically located as close to where members reside as pos-
42 sible and are, if available, offered in nontraditional settings that are accessible to families, diverse
43 communities and underserved populations.

44 “(g) Each coordinated care organization uses health information technology to link services and
45 care providers across the continuum of care to the greatest extent practicable **and if financially**

1 **viable.**

2 “(h) Each coordinated care organization complies with the safeguards for members described in
3 ORS 414.635.

4 “(i) Each coordinated care organization convenes a community advisory council that *[includes*
5 *representatives of the community and of county government, but with consumers making up a majority*
6 *of the membership, and that meets regularly to ensure that the health care needs of the consumers and*
7 *the community are being addressed]* **meets the criteria specified in section 13 of this 2012 Act.**

8 “(j) Each coordinated care organization prioritizes working with members who have high health
9 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
10 members in accessing and managing appropriate preventive, health, remedial and supportive care
11 and services to reduce the use of avoidable emergency room visits and hospital admissions.

12 “(k) Members have a choice of providers within the coordinated care organization’s network and
13 that providers participating in a coordinated care organization:

14 “(A) Work together to develop best practices for care and service delivery to reduce waste and
15 improve the health and well-being of members.

16 “(B) Are educated about the integrated approach and how to access and communicate within the
17 integrated system about a patient’s treatment plan and health history.

18 “(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
19 making and communication.

20 “(D) Are permitted to participate in the networks of multiple coordinated care organizations.

21 “(E) Include providers of specialty care.

22 “(F) Are selected by coordinated care organizations using universal application and credential-
23 ing procedures, objective quality information and are removed if the providers fail to meet objective
24 quality standards.

25 “(G) Work together to develop best practices for culturally appropriate care and service delivery
26 to reduce waste, reduce health disparities and improve the health and well-being of members.

27 “(L) Each coordinated care organization reports on outcome and quality measures *[identified by*
28 *the authority]* **adopted** under ORS 414.638 and participates in the health care data reporting system
29 established in ORS 442.464 and 442.466.

30 “(m) Each coordinated care organization uses best practices in the management of finances,
31 contracts, claims processing, payment functions and provider networks.

32 “(n) Each coordinated care organization participates in the learning collaborative described in
33 ORS 442.210 (3).

34 “(o) Each coordinated care organization has a governance structure that includes:

35 “(A) *[A majority interest consisting of the]* Persons that share in the financial risk of the organ-
36 ization **who must constitute a majority of the governance structure;**

37 “(B) The major components of the health care delivery system; *[and]*

38 “(C) **At least two health care providers in active practice, including:**

39 “(i) **A physician licensed under ORS chapter 677 or a nurse practitioner certified under**
40 **ORS 678.375, whose area of practice is primary care; and**

41 “(ii) **A mental health or chemical dependency treatment provider;**

42 “[*(C)*] **(D) At least two members from** the community at large, to ensure that the
43 organization’s decision-making is consistent with the values of the members and the community[.];

44 **and**

45 “(E) **At least one member of the community advisory council.**

1 “[(2)] (3) The authority shall consider the participation of area agencies and other nonprofit
2 agencies in the configuration of coordinated care organizations.

3 “(4) **In selecting one or more coordinated care organizations to serve a geographic area,**
4 **the authority shall:**

5 “(a) **For members and potential members, optimize access to care and choice of provid-**
6 **ers;**

7 “(b) **For providers, optimize choice in contracting with coordinated care organizations;**
8 **and**

9 “(c) **Allow more than one coordinated care organization to serve the geographic area if**
10 **necessary to optimize access and choice under this subsection.**

11 “[(3)] (5) On or before July 1, 2014, each coordinated care organization must have a formal
12 contractual relationship with any dental care organization that serves members of the coordinated
13 care organization in the area where they reside.

14 “**SECTION 21.** ORS 414.638 is amended to read:

15 “414.638. (1) **There is created a nine-member metrics and scoring committee appointed**
16 **by the Director of the Oregon Health Authority. The members of the committee serve two-**
17 **year terms and must include:**

18 “(a) **Three members at large;**

19 “(b) **Three individuals with expertise in health outcomes measures; and**

20 “(c) **Three representatives of coordinated care organizations.**

21 “[(1)] (2) [*The Oregon Health Authority through a public process shall*] **The committee shall use**
22 **a public process to identify objective outcome and quality measures [and benchmarks], including**
23 **measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and**
24 **mental health treatment, oral health care and all other health services provided by coordinated care**
25 **organizations. Quality measures adopted by the committee must be consistent with existing**
26 **state and national quality measures.** The Oregon Health Authority shall incorporate these
27 measures into coordinated care organization contracts to hold the organizations accountable for
28 performance and customer satisfaction requirements.

29 “(3) **The committee must adopt outcome and quality measures annually and adjust the**
30 **measures to reflect:**

31 “(a) **The amount of the global budget for a coordinated care organization;**

32 “(b) **Changes in membership of the organization;**

33 “(c) **The organization’s costs for implementing outcome and quality measures; and**

34 “(d) **The community health assessment and the costs of the community health assess-**
35 **ment conducted by the organization under section 13 of this 2012 Act.**

36 “[(2)] (4) The authority shall evaluate on a regular and ongoing basis [*key*] **the outcome and**
37 **quality measures adopted by the committee under this section**[, *including health status, experience*
38 *of care and patient activation, along with key demographic variables including race and ethnicity,*] for
39 members in each coordinated care organization and for members statewide.

40 “[(3)] (5) [*Quality measures identified by the authority under this section must be consistent with*
41 *existing state and national quality measures.*] The authority shall utilize available data systems for
42 reporting **outcome and quality measures adopted by the committee** and take actions to elimi-
43 nate any redundant reporting or reporting of limited value.

44 “[(4)] (6) The authority shall publish the information collected under this section at aggregate
45 levels that do not disclose information otherwise protected by law. The information published must

1 report, by coordinated care organization:

2 “(a) Quality measures;

3 “(b) Costs;

4 “(c) Outcomes; and

5 “(d) Other information, as specified by the contract between the coordinated care organization
6 and the authority, that is necessary for the authority, members and the public to evaluate the value
7 of health services delivered by a coordinated care organization.

8 “**SECTION 22.** ORS 646.735 is amended to read:

9 “646.735. (1) The Legislative Assembly declares that collaboration among public payers, private
10 health carriers, third party purchasers and providers to identify appropriate service delivery systems
11 and reimbursement methods to align incentives in support of integrated and coordinated health care
12 delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent
13 to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the
14 state action doctrine, coordinated care organizations that might otherwise be constrained by such
15 laws. [*The Legislative Assembly does not authorize any person or entity to engage in activities or to*
16 *conspire to engage in activities that would constitute per se violations of state or federal antitrust laws*
17 *including, but not limited to, agreements among competing health care providers as to the prices of*
18 *specific health services.*]

19 “(2) The Director of the Oregon Health Authority or the director’s designee [*may*] **shall** engage
20 in appropriate state supervision necessary to promote state action immunity under state and federal
21 antitrust laws, and may inspect or request additional documentation to verify that the Oregon In-
22 tegrated and Coordinated Health Care Delivery System established under ORS 414.620 is imple-
23 mented in accordance with the legislative intent expressed in ORS 414.018.

24 “(3) [*The Oregon Health Authority may convene*] Groups that include, but are not limited to,
25 health insurance companies, health care centers, hospitals, health service organizations, employers,
26 health care providers, health care facilities, state and local governmental entities and consumers,
27 **may meet** to facilitate the development, [*and establishment of the Oregon Integrated and Coordinated*
28 *Health Care Delivery System and health care payment reforms*] **implementation and operation of a**
29 **coordinated care organization in accordance with criteria and requirements adopted by the**
30 **Oregon Health Authority under ORS 414.625.** Any participation by such entities and individuals
31 shall be on a voluntary basis.

32 “(4) The authority may[:]

33 “[*(a)*] conduct a survey of the entities and individuals specified in subsection (3) of this section
34 concerning payment and delivery reforms[; and]

35 “[*(b)*] *Convene meetings at a time and place that is convenient for the entities and individuals*
36 *specified in subsection (3) of this section.*]

37 “(5) A survey or meeting under subsection (3) or (4) of this section is not a violation of state
38 antitrust laws and shall be considered state action for purposes of federal antitrust laws through the
39 state action doctrine.”.

40 In line 40, delete “13” and insert “23”.

41 On page 5, line 3, delete “14” and insert “24”.

42 In line 17, delete “15” and insert “25”.

43 In line 32, delete “16” and insert “26”.

44 In line 45, delete “17” and insert “27”.

45 On page 6, line 24, delete “18” and insert “28”.

1 In line 29, delete "19" and insert "29".

2 In line 35, delete "20" and insert "30".

3
