

A-Engrossed
House Bill 2020

Ordered by the House April 17
Including House Amendments dated April 17

Sponsored by Representative NATHANSON; Representatives CONGER, HUFFMAN, Senator SHIELDS

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.

Requires coordinated care organizations to accept credentials of mental health treatment providers and chemical dependency treatment providers found by another coordinated care organization to meet credentialing requirements [*and objective quality standards*].

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to standards for health care providers serving members of coordinated care organizations;
3 amending ORS 414.625; and declaring an emergency.

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

5 **SECTION 1.** ORS 414.625, as amended by section 20, chapter 8, Oregon Laws 2012, is amended
6 to read:

7 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
8 quirements for a coordinated care organization and shall integrate the criteria and requirements
9 into each contract with a coordinated care organization. Coordinated care organizations may be
10 local, community-based organizations or statewide organizations with community-based participation
11 in governance or any combination of the two. Coordinated care organizations may contract with
12 counties or with other public or private entities to provide services to members. The authority may
13 not contract with only one statewide organization. A coordinated care organization may be a single
14 corporate structure or a network of providers organized through contractual relationships. The cri-
15 teria adopted by the authority under this section must include, but are not limited to, the coordi-
16 nated care organization's demonstrated experience and capacity for:

17 (a) Managing financial risk and establishing financial reserves.

18 (b) Meeting the following minimum financial requirements:

19 (A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the coor-
20 dinated care organization's total actual or projected liabilities above \$250,000.

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

23 (c) Operating within a fixed global budget.

24 (d) Developing and implementing alternative payment methodologies that are based on health
25 care quality and improved health outcomes.

26 (e) Coordinating the delivery of physical health care, mental health and chemical dependency
27 services, oral health care and covered long-term care services.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.
New sections are in **boldfaced** type.

1 (f) Engaging community members and health care providers in improving the health of the
2 community and addressing regional, cultural, socioeconomic and racial disparities in health care
3 that exist among the coordinated care organization's members and in the coordinated care
4 organization's community.

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

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

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

11 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
12 using patient centered primary care homes or other models that support patient centered primary
13 care and individualized care plans to the extent feasible.

14 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
15 tering and leaving an acute care facility or a long term care setting.

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

21 (f) Services and supports are geographically located as close to where members reside as possi-
22 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
23 communities and underserved populations.

24 (g) Each coordinated care organization uses health information technology to link services and
25 care providers across the continuum of care to the greatest extent practicable and if financially vi-
26 able.

27 (h) Each coordinated care organization complies with the safeguards for members described in
28 ORS 414.635.

29 (i) Each coordinated care organization convenes a community advisory council that meets the
30 criteria specified in section 13, chapter 8, Oregon Laws 2012.

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

35 (k) Members have a choice of providers within the coordinated care organization's network and
36 that providers participating in a coordinated care organization:

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

39 (B) Are educated about the integrated approach and how to access and communicate within the
40 integrated system about a patient's treatment plan and health history.

41 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
42 making and communication.

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

44 (E) Include providers of specialty care.

45 (F) Are selected by coordinated care organizations using universal application and credentialing

1 procedures[,] **and** objective quality [*information*] **standards** and are removed if the providers fail to
2 meet **the** objective quality standards.

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

5 (L) Each coordinated care organization reports on outcome and quality measures adopted under
6 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464
7 and 442.466.

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

10 (n) Each coordinated care organization participates in the learning collaborative described in
11 ORS 442.210 (3).

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

13 (A) Persons that share in the financial risk of the organization who must constitute a majority
14 of the governance structure;

15 (B) The major components of the health care delivery system;

16 (C) At least two health care providers in active practice, including:

17 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
18 678.375, whose area of practice is primary care; and

19 (ii) A mental health or chemical dependency treatment provider;

20 (D) At least two members from the community at large, to ensure that the organization's
21 decision-making is consistent with the values of the members and the community; and

22 (E) At least one member of the community advisory council.

23 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
24 in the configuration of coordinated care organizations.

25 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
26 thority shall:

27 (a) For members and potential members, optimize access to care and choice of providers;

28 (b) For providers, optimize choice in contracting with coordinated care organizations; and

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

31 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual
32 relationship with any dental care organization that serves members of the coordinated care organ-
33 ization in the area where they reside.

34 **(6)(a) The authority shall adopt by rule credentialing standards for mental health treat-**
35 **ment providers and chemical dependency treatment providers. The authority shall appoint**
36 **an advisory committee under ORS 183.333 composed of representatives of coordinated care**
37 **organizations, mental health treatment providers and chemical dependency treatment pro-**
38 **viders.**

39 **(b) Mental health treatment providers and chemical dependency treatment providers that**
40 **are determined by one coordinated care organization to meet the credentialing standards**
41 **adopted by the authority meet the credentialing standards of all coordinated care organiza-**
42 **tions.**

43 **(c) A coordinated care organization that has credentialed a mental health treatment**
44 **provider or a chemical dependency treatment provider using the credentialing standards**
45 **adopted by the authority shall provide, upon the request of a coordinated care organization**

1 that subsequently receives a credentialing request from the same provider, sufficient infor-
2 mation to assure the subsequent coordinated care organization that the proper procedures
3 were followed and that the provider meets the credentialing standards.

4 (d) Nothing in this subsection requires a coordinated care organization to contract with
5 any provider that meets the credentialing standards adopted under this subsection.

6 (e) The authority shall adopt by rule the requirements for programs to qualify as mental
7 health treatment providers or chemical dependency treatment providers for the purposes of
8 this subsection.

9 (f) As used in this subsection, “providers” does not include individual practitioners.

10 SECTION 2. This 2013 Act being necessary for the immediate preservation of the public
11 peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect
12 on its passage.

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