House Bill 2522

Sponsored by Representative THOMPSON (Presession filed.)

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 **as introduced.**

Requires coordinated care organization to provide members with access to chiropractic, naturopathic and nurse practitioner services for primary care and access to licensed acupuncturists, licensed massage therapists and licensed optometrists for specialty care and to pay same reimbursement rate for service to all providers of service, regardless of license or certification of provider. Requires coordinated care organizations and prepaid managed care health services organizations to ensure adequacy of provider network. Modifies description of network adequacy.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to ensuring access to a full range of health care providers; creating new provisions; amending ORS 414.625 and 414.645 and section 4, chapter 80, Oregon Laws 2012; repealing section 6, chapter 80, Oregon Laws 2012; and declaring an emergency.

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

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

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

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

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

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

(c) Operating within a fixed global budget.

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

(e) Coordinating the delivery of physical health care, mental health and chemical dependency 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Include **licensed acupuncturists, licensed massage therapists, licensed optometrists and other** providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures, objective quality information and are removed if the providers fail to meet objective quality standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2. ORS 414.645 is amended to read:

414.645. (1) A prepaid managed care health services organization **or a coordinated care organization** that contracts with the Oregon Health Authority must maintain a network of providers **from each health care profession requiring a license or certification in this state,** sufficient in numbers and [*areas of practice and*] geographically distributed [*in a manner*] to ensure that [*the health services provided under the contract are reasonably accessible to*] enrollees **and members have reasonable access, without significant waiting periods or other restrictions, to all types of providers and all services under the contract, including reasonable access to chiropractic physicians, naturopathic physicians and certified nurse practitioners for all primary care services that are within the scope of the provider's license or certification**.

(2) An organization shall pay the same reimbursement rate for a service to all providers

who are acting within the scope of their license or certification. An organization may not vary reimbursement rates solely on the basis of a provider's license or certification.

[*(2)*] **(3)** An enrollee **or member** may transfer from one organization to another organization no more than once during each enrollment period.

SECTION 3. Section 4, chapter 80, Oregon Laws 2012, as amended by section 5, chapter 80, Oregon Laws 2012, is amended to read:

Sec. 4. (1) A coordinated care organization**, fully capitated health plan or physician care organization** may not discriminate with respect to participation in the organization **or plan** or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law. This section does not require that an organization **or plan** contract with any health care provider willing to abide by the terms and conditions for participation established by the organization **or plan**. This section does not prevent an organization **or plan** from establishing varying reimbursement rates based on quality or performance measures.

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

(3) The authority shall adopt by rule a process for resolving claims of discrimination under this section and, in making a determination of whether there has been discrimination, must consider the organization's **or plan's**:

(a) Network adequacy**, as described in ORS 414.645 (1)**;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(4) A prevailing party in an appeal under this section shall be awarded the costs of the appeal.

SECTION 4. Section 4, chapter 80, Oregon Laws 2012, as amended by section 5, chapter 80, Oregon Laws 2012, and section 3 of this 2013 Act is amended to read:

Sec. 4. (1) A coordinated care organization[*, fully capitated health plan or physician care organization*] may not discriminate with respect to participation in the organization [*or plan*] or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law. This section does not require that an organization [*or plan*] contract with any health care provider willing to abide by the terms and conditions for participation established by the organization [*or plan*]. This section does not prevent an organization [*or plan*] from establishing varying reimbursement rates based on quality or performance measures.

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

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

(a) Network adequacy, as described in ORS 414.645 (1);

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(4) A prevailing party in an appeal under this section shall be awarded the costs of the appeal.

SECTION 5. The amendments to section 4, chapter 80, Oregon Laws 2012, by section 4

of this 2013 Act become operative July 1, 2017.

SECTION 6. Section 6, chapter 80, Oregon Laws 2012, is repealed.

SECTION 7. The qualification criteria and requirements specified under ORS 414.625 and 414.645 must be incorporated into any contract between the Oregon Health Authority and a coordinated care organization that is entered into, renewed or extended on or after the effective date of this 2013 Act.

SECTION 8. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.