

(To Resolve Conflicts)

C-Engrossed Senate Bill 832

Ordered by the House June 25
Including Senate Amendments dated April 28 and June 5 and House
Amendments dated June 25 to resolve conflicts

Sponsored by Senators MONNES ANDERSON, WINTERS, BATES; Senators GELSER, KNOPP, STEINER
HAYWARD, Representatives BUEHLER, KENNEMER, WHISNANT

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 Oregon Health Authority to prescribe by rule standards for integrating behavioral health services and physical health services in patient centered primary care homes and behavioral health homes. Defines "behavioral health home." Permits patient centered primary care homes and behavioral health homes to use billing codes applicable to physical and behavioral health services provided in primary care and urgent care settings.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to integrated health care; creating new provisions; amending ORS 413.260, 414.018, 414.025,
3 414.153, 414.620, 414.625, 414.653, 414.655, 414.736, 414.740, 414.760 and 442.210 and section 14,
4 chapter 8, Oregon Laws 2012; and declaring an emergency.

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

6 **SECTION 1. Section 2 of this 2015 Act is added to and made a part of ORS chapter 414.**

7 **SECTION 2. The Oregon Health Authority shall prescribe by rule standards for achieving**
8 **the integration of behavioral health services and physical health services in patient centered**
9 **primary care homes and behavioral health homes.**

10 **SECTION 3. ORS 414.025 is amended to read:**

11 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially
12 applicable statutory definition requires otherwise:

13 (1)(a) "Alternative payment methodology" means a payment other than a fee-for-services pay-
14 ment, used by coordinated care organizations as compensation for the provision of integrated and
15 coordinated health care and services.

16 (b) "Alternative payment methodology" includes, but is not limited to:

17 (A) Shared savings arrangements;

18 (B) Bundled payments; and

19 (C) Payments based on episodes.

20 (2) "Behavioral health clinician" means:

21 (a) A licensed psychiatrist;

22 (b) A licensed psychologist;

23 (c) A certified nurse practitioner with a specialty in psychiatric mental health;

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 **(d) A licensed clinical social worker;**

2 **(e) A licensed professional counselor or licensed marriage and family therapist;**

3 **(f) A certified clinical social work associate;**

4 **(g) An intern or resident who is working under a board-approved supervisory contract in**
5 **a clinical mental health field; or**

6 **(h) Any other clinician whose authorized scope of practice includes mental health diag-**
7 **nosis and treatment.**

8 **(3) “Behavioral health home” means a mental health disorder or substance use disorder**
9 **treatment organization, as defined by the Oregon Health Authority by rule, that provides**
10 **integrated health care to individuals whose primary diagnoses are mental health disorders**
11 **or substance use disorders.**

12 [(2)] **(4) “Category of aid” means assistance provided by the Oregon Supplemental Income Pro-**
13 **gram, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income**
14 **payments.**

15 [(3)] **(5) “Community health worker” means an individual who:**

16 (a) Has expertise or experience in public health;

17 (b) Works in an urban or rural community, either for pay or as a volunteer in association with
18 a local health care system;

19 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
20 ences with the residents of the community where the worker serves;

21 (d) Assists members of the community to improve their health and increases the capacity of the
22 community to meet the health care needs of its residents and achieve wellness;

23 (e) Provides health education and information that is culturally appropriate to the individuals
24 being served;

25 (f) Assists community residents in receiving the care they need;

26 (g) May give peer counseling and guidance on health behaviors; and

27 (h) May provide direct services such as first aid or blood pressure screening.

28 [(4)] **(6) “Coordinated care organization” means an organization meeting criteria adopted by the**
29 **Oregon Health Authority under ORS 414.625.**

30 [(5)] **(7) “Dually eligible for Medicare and Medicaid” means, with respect to eligibility for en-**
31 **rollment in a coordinated care organization, that an individual is eligible for health services funded**
32 **by Title XIX of the Social Security Act and is:**

33 (a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

34 (b) Enrolled in Part B of Title XVIII of the Social Security Act.

35 [(6)] **(8) “Global budget” means a total amount established prospectively by the Oregon Health**
36 **Authority to be paid to a coordinated care organization for the delivery of, management of, access**
37 **to and quality of the health care delivered to members of the coordinated care organization.**

38 [(7)] **(9) “Health services” means at least so much of each of the following as are funded by the**
39 **Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-**
40 **dence Review Commission under ORS 414.690:**

41 (a) Services required by federal law to be included in the state’s medical assistance program in
42 order for the program to qualify for federal funds;

43 (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified
44 under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as
45 defined by state law, and ambulance services;

- 1 (c) Prescription drugs;
- 2 (d) Laboratory and X-ray services;
- 3 (e) Medical equipment and supplies;
- 4 (f) Mental health services;
- 5 (g) Chemical dependency services;
- 6 (h) Emergency dental services;
- 7 (i) Nonemergency dental services;
- 8 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of
- 9 this subsection, defined by federal law that may be included in the state's medical assistance pro-
- 10 gram;
- 11 (k) Emergency hospital services;
- 12 (L) Outpatient hospital services; and
- 13 (m) Inpatient hospital services.

14 [(8)] (10) "Income" has the meaning given that term in ORS 411.704.

15 (11)(a) **"Integrated health care" means care provided to individuals and their families in**

16 **a patient centered primary care home or behavioral health home by licensed primary care**

17 **clinicians, behavioral health clinicians and other care team members, working together to**

18 **address one or more of the following:**

- 19 (A) **Mental illness.**
- 20 (B) **Substance use disorders.**
- 21 (C) **Health behaviors that contribute to chronic illness.**
- 22 (D) **Life stressors and crises.**
- 23 (E) **Developmental risks and conditions.**
- 24 (F) **Stress-related physical symptoms.**
- 25 (G) **Preventive care.**
- 26 (H) **Ineffective patterns of health care utilization.**

27 (b) **As used in this subsection, "other care team members" includes but is not limited to:**

- 28 (A) **Qualified mental health professionals or qualified mental health associates meeting**
- 29 **requirements adopted by the Oregon Health Authority by rule;**
- 30 (B) **Peer wellness specialists;**
- 31 (C) **Peer support specialists;**
- 32 (D) **Community health workers who have completed a state-certified training program;**
- 33 (E) **Personal health navigators; or**
- 34 (F) **Other qualified individuals approved by the Oregon Health Authority.**

35 [(9)] (12) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable

36 instruments as defined in ORS 73.0104 and such similar investments or savings as the department

37 or the authority may establish by rule that are available to the applicant or recipient to contribute

38 toward meeting the needs of the applicant or recipient.

39 [(10)] (13) "Medical assistance" means so much of the medical, mental health, preventive, sup-

40 portive, palliative and remedial care and services as may be prescribed by the authority according

41 to the standards established pursuant to ORS 414.065, including premium assistance and payments

42 made for services provided under an insurance or other contractual arrangement and money paid

43 directly to the recipient for the purchase of health services and for services described in ORS

44 414.710.

45 [(11)] (14) "Medical assistance" includes any care or services for any individual who is a patient

1 in a medical institution or any care or services for any individual who has attained 65 years of age
 2 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-
 3 eases. “Medical assistance” does not include care or services for an inmate in a nonmedical public
 4 institution.

5 [(12)] (15) “Patient centered primary care home” means a health care team or clinic that is or-
 6 ganized in accordance with the standards established by the Oregon Health Authority under ORS
 7 414.655 and that incorporates the following core attributes:

- 8 (a) Access to care;
- 9 (b) Accountability to consumers and to the community;
- 10 (c) Comprehensive whole person care;
- 11 (d) Continuity of care;
- 12 (e) Coordination and integration of care; and
- 13 (f) Person and family centered care.

14 (16) “Peer support specialist” means any of the following individuals who provide sup-
 15 portive services to a current or former consumer of mental health or addiction treatment:

16 (a) An individual who is a current or former consumer of mental health treatment;

17 (b) An individual who is in recovery, as defined by the Oregon Health Authority by rule,
 18 from an addiction disorder; or

19 (c) A family member of a current or former consumer of mental health or addiction
 20 treatment.

21 [(13)] (17) “Peer wellness specialist” means an individual who is responsible for assessing mental
 22 health and substance use disorder service and support needs of [*the individual’s peers*] a member
 23 of a coordinated care organization through community outreach, assisting [*individuals*] members
 24 with access to available services and resources, addressing barriers to services and providing edu-
 25 cation and information about available resources [*and mental health issues*] for individuals with
 26 mental health or substance use disorders in order to reduce [*stigmas*] stigma and discrimination
 27 toward consumers of mental health and substance use disorder services and [*to provide direct*
 28 *services to assist individuals*] to assist the member in creating and maintaining recovery, health
 29 and wellness.

30 [(14)] (18) “Person centered care” means care that:

31 (a) Reflects the individual patient’s strengths and preferences;

32 (b) Reflects the clinical needs of the patient as identified through an individualized assessment;
 33 and

34 (c) Is based upon the patient’s goals and will assist the patient in achieving the goals.

35 [(15)] (19) “Personal health navigator” means an individual who provides information, assistance,
 36 tools and support to enable a patient to make the best health care decisions in the patient’s par-
 37 ticular circumstances and in light of the patient’s needs, lifestyle, combination of conditions and
 38 desired outcomes.

39 [(16)] (20) “Quality measure” means the measures and benchmarks identified by the authority
 40 in accordance with ORS 414.638.

41 [(17)] (21) “Resources” has the meaning given that term in ORS 411.704. For eligibility purposes,
 42 “resources” does not include charitable contributions raised by a community to assist with medical
 43 expenses.

44 **SECTION 4.** ORS 414.153 is amended to read:

45 414.153. In order to make advantageous use of the system of public health care and services

1 available through county health departments and other publicly supported programs and to [*insure*]
2 **ensure** access to public health care and services through contract under ORS chapter 414, the state
3 shall:

4 (1) Unless cause can be shown why such an agreement is not feasible, require and approve
5 agreements between coordinated care organizations and publicly funded providers for authorization
6 of payment for point of contact services in the following categories:

- 7 (a) Immunizations;
- 8 (b) Sexually transmitted diseases; and
- 9 (c) Other communicable diseases;

10 (2) Allow [*enrollees in*] **members of** coordinated care organizations to receive from fee-for-
11 service providers:

- 12 (a) Family planning services;
- 13 (b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention ser-
14 vices; and
- 15 (c) Maternity case management if the Oregon Health Authority determines that a coordinated
16 care organization cannot adequately provide the services;

17 (3) Encourage and approve agreements between coordinated care organizations and publicly
18 funded providers for authorization of and payment for services in the following categories:

- 19 (a) Maternity case management;
- 20 (b) Well-child care;
- 21 (c) Prenatal care;
- 22 (d) School-based clinics;
- 23 (e) Health care and services for children provided through schools and Head Start programs;
- 24 and

25 (f) Screening services to provide early detection of health care problems among low income
26 women and children, migrant workers and other special population groups; and

27 (4) Recognize the responsibility of counties under ORS 430.620 to operate community mental
28 health programs by requiring a written agreement between each coordinated care organization and
29 the local mental health authority in the area served by the coordinated care organization, unless
30 cause can be shown why such an agreement is not feasible under criteria established by the Oregon
31 Health Authority. The written agreements:

32 (a) May not [*limit the ability of*] **prevent** coordinated care organizations [*to contract*] **from**
33 **contracting** with other public or private providers for mental health or chemical dependency ser-
34 vices;

35 (b) Must include agreed upon outcomes; and

36 (c) Must describe the authorization and payments necessary to maintain the mental health safety
37 net system and to maintain the efficient and effective management of the following responsibilities
38 of local mental health authorities, with respect to the service needs of members of the coordinated
39 care organization:

40 (A) Management of children and adults at risk of entering or who are transitioning from the
41 Oregon State Hospital or from residential care;

42 (B) Care coordination of residential services and supports for adults and children;

43 (C) Management of the mental health crisis system;

44 (D) Management of community-based specialized services, including but not limited to supported
45 employment and education, early psychosis programs, assertive community treatment or other types

1 of intensive case management programs and home-based services for children; and

2 (E) Management of specialized services to reduce recidivism of individuals with mental illness
3 in the criminal justice system.

4 **SECTION 5.** ORS 414.655 is amended to read:

5 414.655. (1) The Oregon Health Authority shall establish standards for the utilization of patient
6 centered primary care homes [*in*] **and behavioral health homes** by coordinated care organizations.

7 (2) Each coordinated care organization shall implement, to the maximum extent feasible, patient
8 centered primary care homes **and behavioral health homes**, including developing capacity for ser-
9 vices in settings that are accessible to families, diverse communities and underserved populations,
10 **including the provision of integrated health care.** The organization shall require its other health
11 and services providers to communicate and coordinate care with the patient centered primary care
12 home **or behavioral health home** in a timely manner using electronic health information technol-
13 ogy.

14 (3) Standards established by the authority for the utilization of patient centered primary care
15 homes **and behavioral health homes** by coordinated care organizations may require the use of
16 federally qualified health centers, rural health clinics, school-based health clinics and other safety
17 net providers that qualify as patient centered primary care homes **or behavioral health homes** to
18 ensure the continued critical role of those providers in meeting the needs of underserved popu-
19 lations.

20 (4) **In order to promote the full integration of behavioral health and physical health ser-**
21 **vices in primary care, behavioral health care and urgent care settings, providers in patient**
22 **centered primary care homes and behavioral health homes may use billing codes applicable**
23 **to the behavioral health and physical health services that are provided.**

24 [(4)] (5) Each coordinated care organization shall report to the authority on uniform quality
25 measures prescribed by the authority by rule for patient centered primary care homes **and behav-**
26 **ioral health homes.**

27 [(5)] (6) Patient centered primary care homes **and behavioral health homes** must participate
28 in the learning collaborative described in ORS 442.210 (3).

29 **SECTION 6.** ORS 413.260 is amended to read:

30 413.260. (1) The Oregon Health Authority, in collaboration with health insurers and purchasers
31 of health plans including the Public Employees' Benefit Board, the Oregon Educators Benefit Board
32 and other members of the patient centered primary care home learning collaborative and the patient
33 centered primary care home program advisory committee, shall:

34 (a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans
35 for:

36 (A) Receiving care through patient centered primary care homes that meet the core attributes
37 established in ORS 442.210;

38 (B) Seeking preventative and wellness services;

39 (C) Practicing healthy behaviors; and

40 (D) Effectively managing chronic diseases.

41 (b) Develop, test and evaluate community-based strategies that utilize community health workers
42 to enhance the culturally competent and linguistically appropriate health services provided by pa-
43 tient centered primary care homes in underserved communities.

44 (2) The authority shall focus on patients with chronic health conditions in developing strategies
45 under this section.

1 (3) The authority, in collaboration with the Public Employees' Benefit Board and the Oregon
 2 Educators Benefit Board, shall establish uniform standards for contracts with health benefit plans
 3 providing coverage to public employees to promote the provision of patient centered primary care
 4 homes, especially for enrollees with chronic medical conditions, that are consistent with the uniform
 5 quality measures established [*by the Office for Oregon Health Policy and Research*] under ORS
 6 442.210 (1)(c).

7 (4) The standards established under subsection (3) of this section may direct health benefit plans
 8 to provide incentives to primary care providers who serve vulnerable populations to partner with
 9 health-focused community-based organizations to provide culturally specific health promotion and
 10 disease management services.

11 **SECTION 7. ORS 442.210 is added to and made a part of ORS chapter 413.**

12 **SECTION 8.** ORS 442.210 is amended to read:

13 442.210. (1) There is established in the [*Office for Oregon Health Policy and Research*] **Oregon**
 14 **Health Authority** the patient centered primary care home program. Through this program, the [*of-*
 15 *fice*] **authority** shall:

16 (a) Define core attributes of [*the*] **a patient centered primary care home and a behavioral**
 17 **health home** to promote a reasonable level of consistency of services provided by patient centered
 18 primary care homes **and behavioral health homes** in this state. In defining core attributes related
 19 to ensuring that care is coordinated, the [*office*] **authority** shall focus on determining whether these
 20 patient centered primary care homes **and behavioral health homes** offer comprehensive primary
 21 **and preventive** care, [*including prevention*] **integrated health care** and disease management ser-
 22 vices;

23 (b) Establish a simple and uniform process to identify patient centered primary care homes that
 24 meet the core attributes defined by the [*office*] **authority** under paragraph (a) of this subsection;

25 (c) Develop uniform quality measures that build from nationally accepted measures and allow
 26 for standard measurement of patient centered primary care home **and behavioral health home**
 27 performance;

28 (d) Develop uniform quality measures for acute care hospital and ambulatory services that align
 29 with the patient centered primary care home **and behavioral health home** quality measures de-
 30 veloped under paragraph (c) of this subsection; and

31 (e) Develop policies that encourage the retention of, and the growth in the numbers of, primary
 32 care providers.

33 (2)(a) The Director of the Oregon Health Authority shall appoint an advisory committee to ad-
 34 vise the [*office*] **authority** in carrying out subsection (1) of this section.

35 (b) The director shall appoint to the advisory committee 15 individuals who represent a diverse
 36 constituency and are knowledgeable about patient centered primary care home delivery systems
 37 [*and*], **behavioral health home delivery systems, integrated health care or** health care quality.

38 (c) Members of the advisory committee are not entitled to compensation, but may be reimbursed
 39 for actual and necessary travel and other expenses incurred by them in the performance of their
 40 official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall
 41 be paid out of funds appropriated to the [*office*] **authority** for the purposes of the advisory commit-
 42 tee.

43 (d) The advisory committee shall use public input to guide policy development.

44 (3) The [*office*] **authority** will also establish, as part of the patient centered primary care home
 45 program, [*a*] learning [*collaborative*] **collaboratives** in which state agencies, private health insurance

1 carriers, third party administrators, *[and]* patient centered primary care homes **and behavioral**
 2 **health homes** can:

3 (a) Share information about quality improvement;

4 (b) Share best practices that increase access to culturally competent and linguistically appro-
 5 priate care;

6 (c) Share best practices that increase the adoption and use of the latest techniques in effective
 7 and cost-effective patient centered care;

8 (d) Coordinate efforts to develop and test methods to align financial incentives to support pa-
 9 tient centered primary care homes **and behavioral health homes**;

10 (e) Share best practices for maximizing the utilization of patient centered primary care homes
 11 **and behavioral health homes** by individuals enrolled in medical assistance programs, including
 12 culturally specific and targeted outreach and direct assistance with applications to adults and chil-
 13 dren of racial, ethnic and language minority communities and other underserved populations;

14 (f) Coordinate efforts to conduct research on patient centered primary care homes **and behav-**
 15 **ioral health homes** and evaluate strategies to implement *[the]* patient centered primary care
 16 *[home]* **homes and behavioral health homes that include integrated health care** to improve
 17 health status and quality and reduce overall health care costs; and

18 (g) Share best practices for maximizing integration to ensure that patients have access to com-
 19 prehensive primary **and preventive** care, *[including preventative]* **integrated health care** and dis-
 20 ease management services.

21 (4) The Legislative Assembly declares that collaboration among public payers, private health
 22 carriers, third party purchasers and providers to identify appropriate reimbursement methods to
 23 align incentives in support of patient centered primary care homes **and behavioral health homes**
 24 is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt
 25 from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and
 26 associated payment reforms designed and implemented under subsection (3) of this section that might
 27 otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or
 28 entity to engage in activities or to conspire to engage in activities that would constitute per se vi-
 29 olations of state or federal antitrust laws including, but not limited to, agreements among competing
 30 health care providers or health carriers as to the prices of specific levels of reimbursement for
 31 health care services.

32 (5) The *[office]* **authority** may contract with a public or private entity to facilitate the work of
 33 the learning collaborative described in subsection (3) of this section and may apply for, receive and
 34 accept grants, gifts, payments and other funds and advances, appropriations, properties and services
 35 from the United States, the State of Oregon or any governmental body or agency or from any other
 36 public or private corporation or person for the purpose of establishing and maintaining the
 37 collaborative.

38 **SECTION 9.** ORS 414.018 is amended to read:

39 414.018. (1) It is the intention of the Legislative Assembly to achieve the goals of universal ac-
 40 cess to an adequate level of high quality health care at an affordable cost.

41 (2) The Legislative Assembly finds:

42 (a) A significant level of public and private funds is expended each year for the provision of
 43 health care to Oregonians;

44 (b) The state has a strong interest in assisting Oregon businesses and individuals to obtain
 45 reasonably available insurance or other coverage of the costs of necessary basic health care ser-

1 vices;

2 (c) The lack of basic health care coverage is detrimental not only to the health of individuals
3 lacking coverage, but also to the public welfare and the state's need to encourage employment
4 growth and economic development, and the lack results in substantial expenditures for emergency
5 and remedial health care for all purchasers of health care including the state; and

6 (d) The use of integrated and coordinated health care systems has significant potential to reduce
7 the growth of health care costs incurred by the people of this state.

8 (3) The Legislative Assembly finds that achieving its goals of improving health, increasing the
9 quality, reliability, availability and continuity of care and reducing the cost of care requires an in-
10 tegrated and coordinated health care system in which:

11 (a) Medical assistance recipients and individuals who are dually eligible for both Medicare and
12 Medicaid participate.

13 (b) Health care services, other than Medicaid-funded long term care services, are delivered
14 through coordinated care contracts that use alternative payment methodologies to focus on pre-
15 ventation, improving health equity and reducing health disparities, utilizing patient centered primary
16 care homes, **behavioral health homes**, evidence-based practices and health information technology
17 to improve health and health care.

18 (c) High quality information is collected and used to measure health outcomes, health care
19 quality and costs and clinical health information.

20 (d) Communities and regions are accountable for improving the health of their communities and
21 regions, reducing avoidable health gaps among different cultural groups and managing health care
22 resources.

23 (e) Care and services emphasize preventive services and services supporting individuals to live
24 independently at home or in their community.

25 (f) Services are person centered, and provide choice, independence and dignity reflected in in-
26 dividual plans and provide assistance in accessing care and services.

27 (g) Interactions between the Oregon Health Authority and coordinated care organizations are
28 done in a transparent and public manner.

29 (h) Moneys provided by the federal government for medical education are allocated to the in-
30 stitutions that provide the education.

31 (4) The Legislative Assembly further finds that there is an extreme need for a skilled, diverse
32 workforce to meet the rapidly growing demand for community-based health care. To meet that need,
33 this state must:

34 (a) Build on existing training programs; and

35 (b) Provide an opportunity for frontline care providers to have a voice in their workplace in
36 order to effectively advocate for quality care.

37 (5) As used in subsection (3) of this section:

38 (a) "Community" means the groups within the geographic area served by a coordinated care
39 organization and includes groups that identify themselves by age, ethnicity, race, economic status,
40 or other defining characteristic that may impact delivery of health care services to the group, as
41 well as the governing body of each county located wholly or partially within the coordinated care
42 organization's service area.

43 (b) "Region" means the geographical boundaries of the area served by a coordinated care or-
44 ganization as well as the governing body of each county that has jurisdiction over all or part of the
45 coordinated care organization's service area.

1 **SECTION 10.** ORS 414.620 is amended to read:

2 414.620. (1) There is established the Oregon Integrated and Coordinated Health Care Delivery
3 System. The system shall consist of state policies and actions that make coordinated care organiza-
4 tions accountable for care management and provision of integrated and coordinated health care for
5 each organization's members, managed within fixed global budgets, by providing care so that effi-
6 ciency and quality improvements reduce medical cost inflation while supporting the development of
7 regional and community accountability for the health of the residents of each region and community,
8 and while maintaining regulatory controls necessary to ensure quality and affordable health care for
9 all Oregonians.

10 (2) The Oregon Health Authority shall seek input from groups and individuals who are part of
11 underserved communities, including ethnically diverse populations, geographically isolated groups,
12 seniors, people with disabilities and people using mental health services, and shall also seek input
13 from providers, coordinated care organizations and communities, in the development of strategies
14 that promote person centered care and encourage healthy behaviors, healthy lifestyles and pre-
15 vention and wellness activities and promote the development of patients' skills in self-management
16 and illness management.

17 (3) The authority shall regularly report to the Oregon Health Policy Board, the Governor and
18 the Legislative Assembly on the progress of payment reform and delivery system change including:

- 19 (a) The achievement of benchmarks;
- 20 (b) Progress toward eliminating health disparities;
- 21 (c) Results of evaluations;
- 22 (d) Rules adopted;
- 23 (e) Customer satisfaction;
- 24 (f) Use of patient centered primary care homes **and behavioral health homes**;
- 25 (g) The involvement of local governments in governance and service delivery; and
- 26 (h) Other developments with respect to coordinated care organizations.

27 **SECTION 11.** ORS 414.625 is amended to read:

28 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
29 quirements for a coordinated care organization and shall integrate the criteria and requirements
30 into each contract with a coordinated care organization. Coordinated care organizations may be
31 local, community-based organizations or statewide organizations with community-based participation
32 in governance or any combination of the two. Coordinated care organizations may contract with
33 counties or with other public or private entities to provide services to members. The authority may
34 not contract with only one statewide organization. A coordinated care organization may be a single
35 corporate structure or a network of providers organized through contractual relationships. The cri-
36 teria adopted by the authority under this section must include, but are not limited to, the coordi-
37 nated care organization's demonstrated experience and capacity for:

- 38 (a) Managing financial risk and establishing financial reserves.
- 39 (b) Meeting the following minimum financial requirements:
 - 40 (A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the coor-
41 dinated care organization's total actual or projected liabilities above \$250,000.
 - 42 (B) Maintaining a net worth in an amount equal to at least five percent of the average combined
43 revenue in the prior two quarters of the participating health care entities.
- 44 (c) Operating within a fixed global budget.
- 45 (d) Developing and implementing alternative payment methodologies that are based on health

1 care quality and improved health outcomes.

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

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

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

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

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

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

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

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

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

28 (g) Each coordinated care organization uses health information technology to link services and
29 care providers across the continuum of care to the greatest extent practicable and if financially viable.
30

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

33 (i) Each coordinated care organization convenes a community advisory council that meets the
34 criteria specified in ORS 414.627.

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

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

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

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

45 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-

1 making and communication.

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

3 (E) Include providers of specialty care.

4 (F) Are selected by coordinated care organizations using universal application and credentialing
5 procedures[,] **and** objective quality information and are removed if the providers fail to meet objec-
6 tive quality standards.

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

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

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

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

16 (o) Each coordinated care organization has a governing body that includes:

17 (A) Persons that share in the financial risk of the organization who must constitute a majority
18 of the governing body;

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

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

21 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
22 678.375, whose area of practice is primary care; and

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

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

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

27 (p) Each coordinated care organization's governing body establishes standards for publicizing
28 the activities of the coordinated care organization and the organization's community advisory
29 councils, as necessary, to keep the community informed.

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

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

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

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

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

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

41 **SECTION 12.** ORS 414.653 is amended to read:

42 414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to use
43 alternative payment methodologies that:

44 (a) Reimburse providers on the basis of health outcomes and quality measures instead of the
45 volume of care;

1 (b) Hold organizations and providers responsible for the efficient delivery of quality care;

2 (c) Reward good performance;

3 (d) Limit increases in medical costs; and

4 (e) Use payment structures that create incentives to:

5 (A) Promote prevention;

6 (B) Provide person centered care; and

7 (C) Reward comprehensive care coordination using delivery models such as patient centered
8 primary care homes **and behavioral health homes**.

9 (2) The authority shall encourage coordinated care organizations to utilize alternative payment
10 methodologies that move from a predominantly fee-for-service system to payment methods that base
11 reimbursement on the quality rather than the quantity of services provided.

12 (3) The authority shall assist and support coordinated care organizations in identifying cost-
13 cutting measures.

14 (4) If a service provided in a health care facility is not covered by Medicare because the service
15 is related to a health care acquired condition, the cost of the service may not be:

16 (a) Charged by a health care facility or any health services provider employed by or with priv-
17 ileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

18 (b) Reimbursed by a coordinated care organization.

19 (5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated
20 care organization that contracts with a Type A or Type B hospital or a rural critical access hospi-
21 tal, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services
22 based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordi-
23 nated care organization for the contract period.

24 (b) The authority shall base the global payments to coordinated care organizations that contract
25 with rural hospitals described in this section on the most recent audited Medicare cost report for
26 Oregon hospitals adjusted to reflect the Medicaid mix of services.

27 (c) The authority shall identify any rural hospital that would not be expected to remain finan-
28 cially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection
29 based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the
30 authority may, on a case-by-case basis, require a coordinated care organization to continue to re-
31 imburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs
32 (a) and (b) of this subsection.

33 (d) This subsection does not prohibit a coordinated care organization and a hospital from mu-
34 tually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this
35 subsection.

36 (e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any
37 additional reimbursement for services provided.

38 (6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must
39 comply with federal requirements for payments to providers of Indian health services, including but
40 not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

41 **SECTION 13.** ORS 414.736 is amended to read:

42 414.736. As used in ORS 192.493, this chapter[,] **and** ORS chapter 416 [*and section 9, chapter 867,*
43 *Oregon Laws 2009*]:

44 (1) "Designated area" means a geographic area of the state defined by the Oregon Health Au-
45 thority by rule that is served by a prepaid managed care health services organization.

1 (2) “Fully capitated health plan” means an organization that contracts with the authority on a
2 prepaid capitated basis under ORS 414.618.

3 (3) “Physician care organization” means an organization that contracts with the authority on a
4 prepaid capitated basis under ORS 414.618 to provide the health services described in ORS 414.025
5 [(7)(b)] **(9)(b)**, (c), (d), (e), (f), (g) and (j). A physician care organization may also contract with the
6 authority on a prepaid capitated basis to provide the health services described in ORS 414.025
7 [(7)(k)] **(9)(k)** and (L).

8 (4) “Prepaid managed care health services organization” means a managed physical health,
9 dental, mental health or chemical dependency organization that contracts with the authority on a
10 prepaid capitated basis under ORS 414.618. A prepaid managed care health services organization
11 may be a dental care organization, fully capitated health plan, physician care organization, mental
12 health organization or chemical dependency organization.

13 **SECTION 14.** ORS 414.740 is amended to read:

14 414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under
15 ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this
16 state and that has been issued a certificate of authority by the Department of Consumer and Busi-
17 ness Services as a health care service contractor to provide health services as described in ORS
18 414.025 [(7)(b)] **(9)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on
19 a prepaid capitated basis to provide the health services described in ORS 414.025 [(7)(k)] **(9)(k)** and
20 (L). The authority may accept financial contributions from any public or private entity to help im-
21 plement and administer the contract. The authority shall seek federal matching funds for any fi-
22 nancial contributions received under this section.

23 (2) In a designated area, in addition to the contract described in subsection (1) of this section,
24 the authority shall contract with prepaid managed care health services organizations to provide
25 health services under [ORS 414.631, 414.651 and 414.688 to 414.745] **this chapter**.

26 **SECTION 15.** ORS 414.760 is amended to read:

27 414.760. (1) The Oregon Health Authority shall provide reimbursement in the state’s medical
28 assistance program for services provided by patient centered primary care homes **and behavioral**
29 **health homes**. If practicable, efforts to align financial incentives to support patient centered pri-
30 mary care homes **and behavioral health homes** for enrollees in medical assistance programs should
31 be aligned with efforts of the learning collaborative described in ORS 442.210 (3).

32 (2) The authority shall require each coordinated care organization, to the extent practicable, to
33 offer patient centered primary care homes **and behavioral health homes** that meet the standards
34 established in ORS 414.655.

35 (3) The authority may reimburse patient centered primary care homes **and behavioral health**
36 **homes** for interpretive services provided to people in the state’s medical assistance programs if in-
37 terpretive services qualify for federal financial participation.

38 (4) The authority shall require patient centered primary care homes **and behavioral health**
39 **homes** receiving these reimbursements to report on quality measures described in ORS 442.210
40 (1)(c).

41 **SECTION 16.** Section 14, chapter 8, Oregon Laws 2012, is amended to read:

42 **Sec. 14.** (1) Notwithstanding ORS 414.631 and 414.651, in any area of the state where a coordi-
43 nated care organization has not been certified, the Oregon Health Authority shall continue to con-
44 tract with one or more prepaid managed care health services organizations, as defined in ORS
45 414.736, that serve the area and that are in compliance with contractual obligations owed to the

1 state or local government.

2 (2) Prepaid managed care health services organizations contracting with the authority under
3 this section are subject to the applicable requirements for, and are permitted to exercise the rights
4 of, coordinated care organizations under ORS 414.153, 414.625, 414.635, 414.638, 414.651, 414.655,
5 414.679, 414.712, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515,
6 659.830 and 743.847.

7 (3) The authority may amend contracts that are in place on July 1, 2011, to allow prepaid
8 managed care health services organizations that meet the criteria adopted by the authority under
9 ORS 414.625 to become coordinated care organizations.

10 (4) The authority shall continue to renew the contracts of prepaid managed care health services
11 organizations that have a contract with the authority on July 1, 2011, until the earlier of the date
12 the prepaid managed care health services organization becomes a coordinated care organization or
13 July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no
14 later than July 1, 2017.

15 (5) The authority shall continue to renew contracts or ensure that counties renew contracts
16 with providers of residential chemical dependency treatment until the provider enters into a con-
17 tract with a coordinated care organization but no later than July 1, 2013.

18 (6) Notwithstanding ORS 414.625 (2)(g) and 414.655 (2), the authority shall allow for a period of
19 transition to the full adoption of health information technology by coordinated care organizations,
20 [and] patient centered primary care homes **and behavioral health homes**. The authority shall ex-
21 plore options for assisting providers and coordinated care organizations in funding their use of
22 health information technology.

23 **SECTION 17. Section 2 of this 2015 Act is repealed on June 30, 2017.**

24 **SECTION 18. This 2015 Act being necessary for the immediate preservation of the public**
25 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**
26 **on its passage.**