SB 832-A6
(LC 2197)
5/28/15 (LHF/ps)

PROPOSED AMENDMENTS TO
A-ENGROSSED SENATE BILL 832

On page 1 of the printed A-engrossed bill, delete lines 6 through 23 and delete pages 2 and 3 and insert:

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

"SECTION 3. ORS 414.025 is amended to read:

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

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

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

"(A) Shared savings arrangements;

"(B) Bundled payments; and

"(C) Payments based on episodes.

"**(2) 'Behavioral health clinician' means:**

"(a) A licensed psychiatrist;

"(b) A licensed psychologist;

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

"(d) A licensed clinical social worker;

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

"(f) A certified clinical social work associate;

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

"(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

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

"[*(2)*] **(4)** 'Category of aid' means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

"[*(3)*] **(5)** 'Community health worker' means an individual who:

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

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

"(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

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

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

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

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

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

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

"[*(5)*] **(7)** 'Dually eligible for Medicare and Medicaid' means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

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

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

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

"[*(7)*] **(9)** 'Health services' means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

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

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

"(c) Prescription drugs;

"(d) Laboratory and X-ray services;

"(e) Medical equipment and supplies;

"(f) Mental health services;

"(g) Chemical dependency services;

"(h) Emergency dental services;

"(i) Nonemergency dental services;

"(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

"(k) Emergency hospital services;

"(L) Outpatient hospital services; and

"(m) Inpatient hospital services.

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

"**(11)(a) 'Integrated health care' means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:**

"(A) Mental illness.

"(B) Substance use disorders.

"(C) Health behaviors that contribute to chronic illness.

"(D) Life stressors and crises.

"(E) Developmental risks and conditions.

"(F) Stress-related physical symptoms.

"(G) Preventive care.

"(H) Ineffective patterns of health care utilization.

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

"(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

"(B) Peer wellness specialists;

"(C) Peer support specialists;

"(D) Community health workers who have completed a state-

certified training program;

"(E) Personal health navigators; or

"(F) Other qualified individuals approved by the Oregon Health Authority.

"[*(9)*] **(12)** 'Investments and savings' means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

"[*(10)*] **(13)** 'Medical assistance' means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance and payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

"[*(11)*] **(14)** 'Medical assistance' includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. 'Medical assistance' does not include care or services for an inmate in a nonmedical public institution.

"[*(12)*] **(15)** 'Patient centered primary care home' means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

"(a) Access to care;

"(b) Accountability to consumers and to the community;

"(c) Comprehensive whole person care;

"(d) Continuity of care;

"(e) Coordination and integration of care; and

"(f) Person and family centered care.

"**(16) 'Peer support specialist' means any of the following individuals who provide supportive services to a current or former consumer of mental health or addiction treatment:**

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

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

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

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

"[*(14)*] **(18)** 'Person centered care' means care that:

"(a) Reflects the individual patient's strengths and preferences;

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

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

"[*(15)*] **(19)** 'Personal health navigator' means an individual who provides information, assistance, tools and support to enable a patient to make the

best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

"[*(16)*] **(20)** 'Quality measure' means the measures and benchmarks identified by the authority in accordance with ORS 414.638.

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

On page 4, delete lines 1 through 18.

On page 5, delete lines 24 through 44 and insert:

"SECTION 5. ORS 414.655 is amended to read:

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

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

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

"(4) In order to promote the full integration of behavioral health

and physical health services in primary care, behavioral health care and urgent care settings, providers in patient centered primary care homes and behavioral health homes may use billing codes applicable to the behavioral health and physical health services that are provided.

"[*(4)*] **(5)** Each coordinated care organization shall report to the authority on uniform quality measures prescribed by the authority by rule for patient centered primary care homes **and behavioral health homes**.

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

On page 6, lines 7 and 8, restore the bracketed material and delete the boldfaced material.

Delete lines 28 through 45 and delete page 7.

On page 8, delete lines 1 through 6 and insert:

"SECTION 8. ORS 442.210 is amended to read:

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

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

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

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

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

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

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

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

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

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

"(3) The [*office*] **authority** will also establish, as part of the patient centered primary care home program, [*a*] learning [*collaborative*] **collaboratives** in which state agencies, private health insurance carriers, third party administrators**,** [*and*] patient centered primary care homes **and behavioral health homes** can:

"(a) Share information about quality improvement;

"(b) Share best practices that increase access to culturally competent and linguistically appropriate care;

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

"(d) Coordinate efforts to develop and test methods to align financial incentives to support patient centered primary care homes **and behavioral health homes**;

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

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

"(g) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary **and preventive** care, [*including preventative*] **integrated health care** and disease management services.

"(4) The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate reimbursement methods to align incentives in support of patient centered primary care homes **and behavioral health homes** is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and associated payment reforms designed and implemented under subsection (3) of this section that might otherwise be constrained by such laws. The Legislative Assembly does not

authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the prices of specific levels of reimbursement for health care services.

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

"SECTION 9. ORS 414.018 is amended to read:

"414.018. (1) It is the intention of the Legislative Assembly to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost.

"(2) The Legislative Assembly finds:

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

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

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

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

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

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

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

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

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

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

"(f) Services are person centered, and provide choice, independence and dignity reflected in individual plans and provide assistance in accessing care and services.

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

"(h) Moneys provided by the federal government for medical education are allocated to the institutions that provide the education.

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

"(a) Build on existing training programs; and

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

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

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

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

"SECTION 10. ORS 414.620 is amended to read:

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

"(2) The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage

healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

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

"(a) The achievement of benchmarks;

"(b) Progress toward eliminating health disparities;

"(c) Results of evaluations;

"(d) Rules adopted;

"(e) Customer satisfaction;

"(f) Use of patient centered primary care homes **and behavioral health homes**;

"(g) The involvement of local governments in governance and service delivery; and

"(h) Other developments with respect to coordinated care organizations.

"SECTION 11. ORS 414.625 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.

"(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**, behavioral**

health homes or other models that support patient centered primary care **and behavioral health 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 ORS 414.627.

"(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 providers of specialty care.

"(F) Are selected by coordinated care organizations using universal application and credentialing procedures[,] **and** 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 governing body that includes:

"(A) Persons that share in the financial risk of the organization who must

constitute a majority of the governing body;

"(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.

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

"(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 12. ORS 414.653 is amended to read:

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

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

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

"(c) Reward good performance;

"(d) Limit increases in medical costs; and

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

"(A) Promote prevention;

"(B) Provide person centered care; and

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

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

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

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

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

"(b) Reimbursed by a coordinated care organization.

"(5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470,

shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

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

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

"(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

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

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

In line 7, delete "9" and insert "13".

In line 16, delete "(8)(b)" and insert "(9)(b)".

In line 18, delete "(8)(k)" and insert "(9)(k)".

In line 24, delete "10" and insert "14".

In line 29, delete "(8)(b)" and insert "(9)(b)".

In line 30, delete "(8)(k)" and insert "(9)(k)".

After line 36, insert:

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

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

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

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

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

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

"**Sec. 14.** (1) Notwithstanding ORS 414.631 and 414.651, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

"(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under ORS 414.153, 414.625, 414.635, 414.638, 414.651, 414.655, 414.679,

414.712, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.

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

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

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

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

In line 37, delete "11" and insert "17".

In line 38, delete "12" and insert "18".
