

**A-Engrossed**  
**House Bill 2122**

Ordered by the House April 19  
Including House Amendments dated April 19

Sponsored by Representative GREENLICK; Representative HOLVEY (Pre-session 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.

Modifies requirements for coordinated care organizations. [*in 2018 and 2023. Beginning in 2023,*] **Makes all meetings of governing body of coordinated care organization and community advisory council subject to open meetings law and requires coordinated care organization to spend earnings above specified threshold on services designed to address health disparities and social determinants of health.** Requires **new** coordinated care organizations **and coordinated care organizations that transfer ownership to new entity** to be community-based [*nonprofit*] **tax exempt** organizations[, *to have membership of governing body that reflects local control and to distribute at least 80 percent of payments to providers using alternative payment methodologies*].

[*Creates Community Escrow Fund in State Treasury to hold coordinated care organization restricted reserves.*]

[*Requires Oregon Health Policy Board to adopt minimum criteria for continuation of contracts with coordinated care organization.*]

[*Requires coordinated care organizations seeking to contract with Oregon Health Authority in 2018 to present plan for moving toward 2023 requirements and to explain steps taken to innovate health care delivery.*]

**Declares emergency, effective on passage.**

**A BILL FOR AN ACT**

1  
2 Relating to coordinated care organizations; creating new provisions; amending ORS 414.025, 414.625  
3 and 414.627; and declaring an emergency.

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

5 **SECTION 1. Sections 2 and 3 of this 2017 Act are added to and made a part of ORS**  
6 **chapter 414.**

7 **SECTION 2. (1) Notwithstanding ORS 414.625 (1) and (2)(o), a coordinated care organiza-**  
8 **tion described in subsection (2) of this section must be a community-based organization that**  
9 **is recognized as tax exempt under section 501(c)(3) of the Internal Revenue Code of 1986.**

10 **(2) This section applies to a coordinated care organization that:**

11 **(a) Does not have a contract with the Oregon Health Authority on the effective date of**  
12 **this 2017 Act; or**

13 **(b) Transfers ownership of the coordinated care organization to another entity after the**  
14 **effective date of this 2017 Act.**

15 **SECTION 3. All meetings of the governing body of a coordinated care organization are**  
16 **subject to ORS 192.610 to 192.690.**

17 **SECTION 4. ORS 414.625 is amended to read:**

18 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
19 quirements for a coordinated care organization and shall integrate the criteria and requirements  
20 into each contract with a coordinated care organization. Coordinated care organizations may be

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

9 (a) **Have demonstrated experience and a capacity for** managing financial risk and establish-  
 10 ing financial reserves.

11 (b) [*Meeting*] **Meet** the following minimum financial requirements:

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

14 (B) [*Maintaining*] **Maintain** a net worth in an amount equal to at least five percent of the av-  
 15 erage combined revenue in the prior two quarters of the participating health care entities.

16 (C) **With the approval of the authority, expend all of the earnings of the coordinated care**  
 17 **organization that exceed the financial requirements of this paragraph on services designed**  
 18 **to address health disparities and the social determinants of health consistent with the coor-**  
 19 **ordinated care organization's community health improvement plan.**

20 (c) [*Operating*] **Operate** within a fixed global budget.

21 (d) [*Developing and implementing*] **Develop and implement** alternative payment methodologies  
 22 that are based on health care quality and improved health outcomes.

23 (e) [*Coordinating*] **Coordinate** the delivery of physical health care, mental health and chemical  
 24 dependency services, oral health care and covered long-term care services.

25 (f) [*Engaging*] **Engage** community members and health care providers in improving the health  
 26 of the community and addressing regional, cultural, socioeconomic and racial disparities in health  
 27 care that exist among the coordinated care organization's members and in the coordinated care  
 28 organization's community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (E) Include providers of specialty care.

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

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

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

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

35 (n) Each coordinated care organization participates in the learning collaborative described in  
36 ORS 413.259 (3).

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

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

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

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

42 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS  
43 678.375, whose area of practice is primary care; and

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

45 (D) At least two members from the community at large, to ensure that the organization's

1 decision-making is consistent with the values of the members and the community; and

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

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

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

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

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

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

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

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

17 **SECTION 5.** ORS 414.627 is amended to read:

18 414.627. (1) A coordinated care organization must have a community advisory council to ensure  
19 that the health care needs of the consumers and the community are being addressed. The council  
20 must:

21 (a) Include representatives of the community and of each county government served by the co-  
22 ordinated care organization, but consumer representatives must constitute a majority of the mem-  
23 bership; and

24 (b) Have its membership selected by a committee composed of equal numbers of county repre-  
25 sentatives from each county served by the coordinated care organization and members of the gov-  
26 erning body of the coordinated care organization.

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

28 (a) Identifying and advocating for preventive care practices to be utilized by the coordinated  
29 care organization;

30 (b) Overseeing a community health assessment and adopting a community health improvement  
31 plan to serve as a strategic population health and health care system service plan for the community  
32 served by the coordinated care organization; and

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

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

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

40 (b) Health policy;

41 (c) System design;

42 (d) Outcome and quality improvement;

43 (e) Integration of service delivery; and

44 (f) Workforce development.

45 (4) The council shall meet at least once every three months. The council shall post a report

1 of its meetings and discussions to the website of the coordinated care organization and other  
2 websites appropriate to keeping the community informed of the council’s activities. The council, the  
3 governing body of the coordinated care organization or a designee of the council or governing body  
4 has discretion as to whether public comments received at meetings that are open to the public will  
5 be included in the reports posted to the website and, if so, which comments are appropriate for  
6 posting.

7 (5) If the regular council meetings are not open to the public and do not provide an opportunity  
8 for members of the public to provide written and oral comments, the council shall hold quarterly  
9 meetings:

10 (a) That are open to the public and attended by the members of the council;

11 (b) At which the council shall report on the activities of the coordinated care organization and  
12 the council;

13 (c) At which the council shall provide written reports on the activities of the coordinated care  
14 organization; and

15 (d) At which the council shall provide the opportunity for the public to provide written or oral  
16 comments.

17 (6) The coordinated care organization shall post to the organization’s website contact informa-  
18 tion for, at a minimum, the chairperson, a member of the community advisory council or a desig-  
19 nated staff member of the organization.

20 (7) Meetings of the council are [*not*] subject to ORS 192.610 to 192.690.

21 **SECTION 6.** ORS 414.025, as amended by section 9, chapter 389, Oregon Laws 2015, is amended  
22 to read:

23 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially  
24 applicable statutory definition requires otherwise:

25 (1)(a) “Alternative payment methodology” means a payment other than a fee-for-services pay-  
26 ment, used by coordinated care organizations as compensation for the provision of integrated and  
27 coordinated health care and services.

28 (b) “Alternative payment methodology” includes, but is not limited to:

29 (A) Shared savings arrangements;

30 (B) Bundled payments; and

31 (C) Payments based on episodes.

32 (2) “Behavioral health clinician” means:

33 (a) A licensed psychiatrist;

34 (b) A licensed psychologist;

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

36 (d) A licensed clinical social worker;

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

38 (f) A certified clinical social work associate;

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

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

43 (3) “Behavioral health home” means a mental health disorder or substance use disorder treat-  
44 ment organization, as defined by the Oregon Health Authority by rule, that provides integrated  
45 health care to individuals whose primary diagnoses are mental health disorders or substance use

1 disorders.

2 (4) "Category of aid" means assistance provided by the Oregon Supplemental Income Program,  
3 aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security  
4 Income payments.

5 (5) "Community health worker" means an individual who:

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

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

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

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

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

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

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

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

18 (6) "Coordinated care organization" means an organization meeting criteria adopted by the  
19 Oregon Health Authority under ORS 414.625.

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

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

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

25 (8) "Global budget" means a total amount established prospectively by the Oregon Health Au-  
26 thority to be paid to a coordinated care organization for the delivery of, management of, access to  
27 and quality of the health care delivered to members of the coordinated care organization.

28 (9) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange  
29 described in 42 U.S.C. 18031, 18032, 18033 and 18041.

30 (10) "Health services" means at least so much of each of the following as are funded by the  
31 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-  
32 dence Review Commission under ORS 414.690:

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

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

38 (c) Prescription drugs;

39 (d) Laboratory and X-ray services;

40 (e) Medical equipment and supplies;

41 (f) Mental health services;

42 (g) Chemical dependency services;

43 (h) Emergency dental services;

44 (i) Nonemergency dental services;

45 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of

1 this subsection, defined by federal law that may be included in the state’s medical assistance pro-  
2 gram;

3 (k) Emergency hospital services;

4 (L) Outpatient hospital services; and

5 (m) Inpatient hospital services.

6 (11) “Income” has the meaning given that term in ORS 411.704.

7 (12)(a) “Integrated health care” means care provided to individuals and their families in a pa-  
8 tient centered primary care home or behavioral health home by licensed primary care clinicians,  
9 behavioral health clinicians and other care team members, working together to address one or more  
10 of the following:

11 (A) Mental illness.

12 (B) Substance use disorders.

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

14 (D) Life stressors and crises.

15 (E) Developmental risks and conditions.

16 (F) Stress-related physical symptoms.

17 (G) Preventive care.

18 (H) Ineffective patterns of health care utilization.

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

20 (A) Qualified mental health professionals or qualified mental health associates meeting require-  
21 ments adopted by the Oregon Health Authority by rule;

22 (B) Peer wellness specialists;

23 (C) Peer support specialists;

24 (D) Community health workers who have completed a state-certified training program;

25 (E) Personal health navigators; or

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

27 (13) “Investments and savings” means cash, securities as defined in ORS 59.015, negotiable in-  
28 struments as defined in ORS 73.0104 and such similar investments or savings as the department or  
29 the authority may establish by rule that are available to the applicant or recipient to contribute  
30 toward meeting the needs of the applicant or recipient.

31 (14) “Medical assistance” means so much of the medical, mental health, preventive, supportive,  
32 palliative and remedial care and services as may be prescribed by the authority according to the  
33 standards established pursuant to ORS 414.065, including premium assistance and payments made for  
34 services provided under an insurance or other contractual arrangement and money paid directly to  
35 the recipient for the purchase of health services and for services described in ORS 414.710.

36 (15) “Medical assistance” includes any care or services for any individual who is a patient in  
37 a medical institution or any care or services for any individual who has attained 65 years of age  
38 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-  
39 eases. Except as provided in ORS 411.439 and 411.447, “medical assistance” does not include care  
40 or services for a resident of a nonmedical public institution.

41 (16) “Patient centered primary care home” means a health care team or clinic that is organized  
42 in accordance with the standards established by the Oregon Health Authority under ORS 414.655  
43 and that incorporates the following core attributes:

44 (a) Access to care;

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

- 1 (c) Comprehensive whole person care;
- 2 (d) Continuity of care;
- 3 (e) Coordination and integration of care; and
- 4 (f) Person and family centered care.

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

- 7 (a) An individual who is a current or former consumer of mental health treatment;
- 8 (b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from  
9 an addiction disorder; or
- 10 (c) A family member of a current or former consumer of mental health or addiction treatment.

11 (18) "Peer wellness specialist" means an individual who is responsible for assessing mental  
12 health and substance use disorder service and support needs of a member of a coordinated care or-  
13 ganization through community outreach, assisting members with access to available services and  
14 resources, addressing barriers to services and providing education and information about available  
15 resources for individuals with mental health or substance use disorders in order to reduce stigma  
16 and discrimination toward consumers of mental health and substance use disorder services and to  
17 assist the member in creating and maintaining recovery, health and wellness.

18 (19) "Person centered care" means care that:

- 19 (a) Reflects the individual patient's strengths and preferences;
- 20 (b) Reflects the clinical needs of the patient as identified through an individualized assessment;  
21 and
- 22 (c) Is based upon the patient's goals and will assist the patient in achieving the goals.

23 (20) "Personal health navigator" means an individual who provides information, assistance, tools  
24 and support to enable a patient to make the best health care decisions in the patient's particular  
25 circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired  
26 outcomes.

27 (21) "Prepaid managed care health services organization" means a managed dental care, mental  
28 health or chemical dependency organization that contracts with the authority under ORS 414.654  
29 or with a coordinated care organization on a prepaid capitated basis to provide health services to  
30 medical assistance recipients.

31 (22) "Quality measure" means the health outcome and quality measures and benchmarks identi-  
32 fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in  
33 accordance with ORS 413.017 (4) and 414.638.

34 (23) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "re-  
35 sources" does not include charitable contributions raised by a community to assist with medical  
36 expenses.

37 (24) "**Social determinants of health**" means **the conditions in which individuals are born,**  
38 **grow, live, work and age, including but not limited to food, safe housing, economic opportu-**  
39 **nities, health care, transportation and education.**

40 **SECTION 7. Section 3 of this 2017 Act and the amendments to ORS 414.025, 414.625 and**  
41 **414.627 by sections 4 to 6 of this 2017 Act apply:**

42 (1) **To coordinated care organizations that have contracts with the Oregon Health Au-**  
43 **thority on the effective date of this 2017 Act.**

44 (2) **Beginning on the effective date of the next contract between the coordinated care**  
45 **organization and the authority that is entered into, amended or renewed on or after the ef-**



1 **fective date of this 2017 Act.**

2 **SECTION 8. This 2017 Act being necessary for the immediate preservation of the public**  
3 **peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect**  
4 **on its passage.**

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