

A-Engrossed
House Bill 2834

Ordered by the House April 24
Including House Amendments dated April 24

Sponsored by COMMITTEE ON HEALTH CARE

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 conduct study of effectiveness of Oregon Integrated and Coordinated Health Care Delivery System in improving health outcomes for medical assistance recipients.]

Requires dental care organization that contracts with coordinated care organization to provide oral health care services to low income seniors and veterans residing in geographic area served by coordinated care organization who do not have other coverage for oral health care services.

A BILL FOR AN ACT

1
2 Relating to health care; creating new provisions; and amending ORS 414.625.

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

4 **SECTION 1. Section 2 of this 2017 Act is added to and made a part of ORS chapter 414.**

5 **SECTION 2. A dental care organization that contracts with a coordinated care organ-**
6 **ization to serve members of the coordinated care organization must provide oral health care**
7 **services to an individual who resides within the geographic area served by the dental care**
8 **organization if the individual:**

9 (1) **Has family income, determined in accordance with rules adopted by the Oregon Health**
10 **Authority, that is at or below 250 percent of the federal poverty guidelines;**

11 (2) **Does not have oral health care coverage provided by:**

12 (a) **The medical assistance program;**

13 (b) **Employer-sponsored health insurance; or**

14 (c) **The United States Department of Veterans Affairs; and**

15 (3)(a) **Is a veteran; or**

16 (b) **Is 65 years of age or older.**

17 **SECTION 3. 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
21 local, community-based organizations or statewide organizations with community-based participation
22 in governance or any combination of the two. Coordinated care organizations may contract with
23 counties or with other public or private entities to provide services to members. The authority may
24 not contract with only one statewide organization. A coordinated care organization may be a single
25 corporate structure or a network of providers organized through contractual relationships. The cri-

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 teria adopted by the authority under this section must include, but are not limited to, the coordi-
2 nated care organization's demonstrated experience and capacity for:

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

4 (b) Meeting the following minimum financial requirements:

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

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

9 (c) Operating within a fixed global budget.

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

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

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

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

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

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

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

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

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

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

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

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

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

45 (j) Each coordinated care organization prioritizes working with members who have high health

1 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
2 members in accessing and managing appropriate preventive, health, remedial and supportive care
3 and services to reduce the use of avoidable emergency room visits and hospital admissions.

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

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

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

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

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

13 (E) Include providers of specialty care.

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

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

19 (L) Each coordinated care organization:

20 (A) Reports on outcome and quality measures adopted under ORS 414.638 [and];

21 (B) Participates in the health care data reporting system established in ORS 442.464 and
22 442.466; and

23 **(C) Reports information about dental care organizations contracting with the coordinated**
24 **care organization, as prescribed by the authority, as necessary to ensure compliance with**
25 **section 2 of this 2017 Act.**

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

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

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

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

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

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

35 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
36 678.375, whose area of practice is primary care; and

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

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

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

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

44 **(q) Each dental care organization contracting with a coordinated care organization com-**
45 **plies with the requirements of section 2 of this 2017 Act.**

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

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

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

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

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

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

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