A-Engrossed
House Bill 3091

Ordered by the House April 21
Including House Amendments dated April 21

Sponsored by Representative KENY-GUYER, Senator GELSER, Representative GREENLICK; Representatives HACK, KOTEK, MALSTROM, NOSSE, Senators BOQUIST, STEINER HAYWARD

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 specified facilities to provide certain case management and behavioral health services to individual who presents at facility experiencing behavioral health crisis.*]

Specifies behavioral health services that must be provided by coordinated care organization.

Expands scope of emergency services that must be covered by health benefit plan to include treatment for behavioral health crisis.

[*Modifies entities eligible for insurance reimbursement for mental health and chemical dependency treatment.*]

Requires group health insurance policy to cover specified behavioral health services.

A BILL FOR AN ACT

Relating to behavioral health treatment; creating new provisions; and amending ORS 414.025, 414.625, 414.736, 414.740, 743A.012 and 743A.168.

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

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

SECTION 2. Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must provide behavioral health services to its members that include but are not limited to all of the following:

(1) For a member who is experiencing a behavioral health crisis:

(a) A behavioral health assessment; and

(b) Services that are medically necessary to transition the member to a lower level of care;

(2) At least the minimum level of services that are medically necessary to treat a member's behavioral health condition as determined in a behavioral health assessment of the member or specified in the member's care plan; and

(3) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

SECTION 3. ORS 414.025, as amended by section 9, chapter 389, Oregon Laws 2015, 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

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.

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 assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

[*(2)*] **(3)** "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.

(4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

[*(3)*] **(5)** "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.

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

[*(5)*] **(7)** "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.

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

[*(7)*] **(9)** "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.

[*(8)*] **(10)** "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.

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

[*(10)*] **(12)** "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**, a behavioral health clinician** 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.

[*(11)*] **(13)** "Income" has the meaning given that term in ORS 411.704.

[*(12)(a)*] **(14)(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.

[*(13)*] **(15)** "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.

[*(14)*] **(16)** "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.

[*(15)*] **(17)** "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. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

[*(16)*] **(18)** "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.

[*(17)*] **(19)** "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.

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

[*(19)*] **(21)** "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.

[*(20)*] **(22)** "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.

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

[*(22)*] **(24)** "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

[*(23)*] **(25)** "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.

SECTION 4. ORS 743A.012 is amended to read:

743A.012. (1) As used in this section:

(a) "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

(b) "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.

(c) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

[*(a)*] **(d)** "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part; [*or*]

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child**; or**

(C) That is a behavioral health crisis.

[*(b)*] **(e)** "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

[*(c)*] **(f)** "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam **or behavioral health assessment** that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

[*(d)*] **(g)** "Grandfathered health plan" has the meaning given that term in ORS 743B.005.

[*(e)*] **(h)** "Health benefit plan" has the meaning given that term in ORS 743B.005.

[*(f)*] **(i)** "Prior authorization" has the meaning given that term in ORS 743B.001.

[*(g)*] **(j)** "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.

(6) This section is exempt from ORS 743A.001.

SECTION 5. ORS 743A.168, as amended by section 7, chapter 11, Oregon Laws 2016, is amended to read:

743A.168. [*A group health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:*]

(1) As used in this section:

(a) "Behavioral health assessment" means an evaluation by a provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment.

(b) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

[*(a)*] **(c)** "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

[*(b)*] **(d)** "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

[*(c)*] **(e)** "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

[*(d)*] **(f)** "Program" means a particular type or level of service that is organizationally distinct within a facility.

[*(e)*] **(g)** "Provider" means [*a person that*]:

(A) **An individual who** has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is[*:*] **a behavioral health professional or a medical professional licensed or certified in this state;**

[*(i)*] **(B)** A health **care** facility as defined in ORS [*430.010*] **433.060**;

[*(ii)*] **(C)** A residential facility as defined in ORS 430.010;

[*(iii)*] **(D)** A day or partial hospitalization program [*as defined in ORS 430.010*];

[*(iv)*] **(E)** An outpatient service as defined in ORS 430.010; or

[*(v) An individual behavioral health or medical professional licensed or certified under Oregon law; or*]

[*(B)*] **(F)** [*Is*] A provider organization certified by the Oregon Health Authority under subsection [*(13)*] **(7)** of this section.

(2) A group health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of and treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

[*(2)*] **(a)** The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health **care** facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

[*(3)*] **(b)** The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

[*(4)(a) Nothing in this section requires coverage for:*]

[*(A) Educational or correctional services or sheltered living provided by a school or halfway house;*]

[*(B) A long-term residential mental health program that lasts longer than 45 days;*]

[*(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or*]

[*(D) A court-ordered sex offender treatment program.*]

[*(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.*]

[*(5)*] **(c) The coverage must include:**

(A) A behavioral health assessment;

(B) No less than the level of services determined to be medically necessary in a behavioral health assessment of a patient or in a patient's care plan:

(i) To treat the patient's behavioral health condition; and

(ii) For care following a behavioral health crisis, to transition the patient to a lower level of care; and

(C) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

(d) A provider is eligible for reimbursement under this section if:

[*(a)*] **(A)** The provider is approved or certified by the Oregon Health Authority;

[*(b)*] **(B)** The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

[*(c)*] **(C)** The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

[*(d)*] **(D)** The provider is providing a covered benefit under the policy.

[*(6) Payments may not be made under this section for support groups.*]

[*(7)*] **(e)** If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

[*(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.*]

[*(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.*]

[*(10)(a)*] **(f)(A)** Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

[*(b)*] **(B)** Review shall be made according to criteria made available to providers in advance upon request.

[*(c)*] **(C)** Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

[*(d)*] **(D)** Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

[*(11)*] **(g)** Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to

limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(3) This section does not prohibit a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section.

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference.

[*(12)*] **(5)** [*Nothing in*] This section [*prevents*] **does not prevent** a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743B.460 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all providers that are eligible for reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to [*subsections (2) and (3)*] **subsection (2)** of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to [*subsections (2) and (3)*] **subsection (2)** of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(6)(a) This section does not require coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) Support groups.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

[*(13)*] **(7)** The Oregon Health Authority shall establish a process for the certification of an organization described in subsection [*(1)(e)(B)*] **(1)(g)(F)** of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community mental health program.

[*(14)*] **(8)** The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection [*(13)*] **(7)** of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

[*(15)*] **(9)** The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection [*(13)*] **(7)** of this section. Any fees collected shall be paid into the Oregon Health Authority

Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection [*(13)*] **(7)** of this section.

[*(16)*] **(10)** The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection [*(13)*] **(7)** of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

[*(17)*] **(11)** The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section.

SECTION 6. 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**, including the services described in section 2 of this 2017 Act,** 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 413.259 (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 7. ORS 414.736 is amended to read:

414.736. As used in this chapter:

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

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

(3) "Physician care organization" means an organization that contracts with the authority on a prepaid capitated basis under ORS 414.618 to provide the health services described in ORS 414.025 [*(10)(b)*] **(12)(b)**, (c), (d), (e), (f), (g) and (j). A physician care organization may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.025 [*(10)(k)*] **(12)(k)** and (L).

SECTION 8. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS 414.025 [*(10)(b)*] **(12)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS 414.025 [*(10)(k)*] **(12)(k)** and (L). The authority may accept financial contributions from any public or private entity to help

implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services under this chapter.