Senate Bill 994

Sponsored by Senator ROBLAN

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 **as introduced.**

Modifies requirements for coordinated care organizations. Specifies grounds for renewal of coordinated care organization contracts in 2019 and 2024.

A BILL FOR AN ACT

Relating to requirements for coordinated care organizations; creating new provisions; and amending ORS 414.625.

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

SECTION 1. (1) As used in this section:

(a) "Community-based" means having a:

(A) Headquarters in the geographic area served; and

(B) Governing body composed of individuals who reside in the geographic area served.

(b) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(c) "Incentive payment" means a payment made by the Oregon Health Authority to a coordinated care organization to reward the achievement by the coordinated care organization of quality measures or to reward the improvement made by the coordinated care organization toward achieving the quality measures.

(d) "Quality measure" has the meaning given that term in ORS 414.025.

(2) Subject to ORS 414.652, the Oregon Health Authority shall renew a contract with a coordinated care organization if, at the end of the term of the contract that is under consideration for renewal, the coordinated care organization:

(a) Is community-based;

(b) Is not in material breach of the contract between the coordinated care organization and the authority;

(c) Has achieved a score of at least 80 percent on the quality measures; and

(d) Has earned at least 80 percent of the incentive payments made available under the contract.

(3) Subsection (2) of this section applies to contracts between coordinated care organizations and the authority that are renewed effective on or after January 1, 2019.

SECTION 2. Section 1 of this 2017 Act is amended to read:

Sec. 1. (1) As used in this section:

(a) "Community-based" means having a:

(A) Headquarters in the geographic area served; and

(B) Governing body composed of individuals who reside in the geographic area served.

(b) "Coordinated care organization" has the meaning given that term in ORS 414.025.

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.

[*(c) "Incentive payment" means a payment made by the Oregon Health Authority to a coordinated care organization to reward the achievement by the coordinated care organization of quality measures or to reward the improvement made by the coordinated care organization toward achieving the quality measures.*]

(c) "Medical loss ratio" means the percentage of each global payment that a coordinated care organization spends on or invests in providing health care and engaging in quality improvement activities, excluding any amounts spent on administrative services or marketing.

(d) "Quality improvement activities" includes but is not limited to:

(A) Reimbursing providers using alternative payment methodologies;

(B) Paying bonuses to providers for high quality care;

(C) Making payments to providers based on cost savings;

(D) Making payments or providing items or services to members that are intended to address the social determinants of health for the members;

(E) Producing educational materials and products for members to improve their health outcomes or quality of life;

(F) Providing gifts or grants to organizations that address members' social determinants of health and access to health care; and

(G) Coordinating and integrating care for members.

[*(d)*] **(e)** "Quality measure" has the meaning given that term in ORS 414.025.

(f) "Social determinants of health" means the conditions in which individuals are born, grow, live, work and age, including but not limited to food, housing, economic opportunities, transportation and education.

(2) Subject to ORS 414.652, the Oregon Health Authority shall renew a contract with a coordinated care organization if, at the end of the term of the contract that is under consideration for renewal, the coordinated care organization:

(a) Is community-based;

(b) Is not in material breach of the contract between the coordinated care organization and the authority;

(c) Has achieved a score of at least 80 percent on the quality measures; [*and*]

[*(d) Has earned at least 80 percent of the incentive payments made available under the contract.*]

(d) By January 1, 2019, met the capital or surplus reserve requirements described in ORS 731.554 and maintained the reserves throughout the term of the contract; and

(e) Reported an average medical loss ratio of no less than 85 percent during the term of the contract.

(3) In calculating the medical loss ratio, the authority may not reduce the amount of a coordinated care organization's expenditures for quality improvement activities by:

(a) Demanding a refund of any amounts spent by the coordinated care organization on the activities;

(b) Modifying, reducing or otherwise limiting the reimbursement paid for the activities; or

(c) Excluding any expenditures on the activities from the calculation of medical loss ratio.

[*(3)*] **(4)** Subsection (2) of this section applies to contracts between coordinated care organizations and the authority that are renewed effective on or after January 1, [*2019*] **2024**.

SECTION 3. 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*] **shall** 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*] **capital or surplus reserves described in ORS 731.554 (1)**.

(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[,] **and** 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 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.

(6) The authority may not establish a regional entity or any other type of intermediary entity that exercises control over a coordinated care organization.

SECTION 4. The amendments to section 1 of this 2017 Act by section 2 of this 2017 Act become operative January 1, 2024.

SECTION 5. Section 1 of this 2017 Act is repealed on January 2, 2029.