

Requested by Representative GREENLICK

**PROPOSED AMENDMENTS TO
HOUSE BILL 2122**

1 On page 1 of the printed bill, line 2, after the second semicolon delete the
2 rest of the line and line 3 and insert “amending ORS 414.025, 414.625 and
3 414.627; and declaring an emergency.”.

4 Delete lines 5 through 26 and delete pages 2 through 8 and insert:

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

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

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

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

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

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

18 **“SECTION 4. ORS 414.625 is amended to read:**

19 **“414.625. (1) The Oregon Health Authority shall adopt by rule the quali-**
20 **fication criteria and requirements for a coordinated care organization and**
21 **shall integrate the criteria and requirements into each contract with a co-**

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

12 “(a) **Have demonstrated experience and a capacity for** managing fi-
13 nancial risk and establishing financial reserves.

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

15 “(A) [*Maintaining*] **Maintain** restricted reserves of \$250,000 plus an
16 amount equal to 50 percent of the coordinated care organization’s total ac-
17 tual or projected liabilities above \$250,000.

18 “(B) [*Maintaining*] **Maintain** a net worth in an amount equal to at least
19 five percent of the average combined revenue in the prior two quarters of the
20 participating health care entities.

21 “(C) **With the approval of the authority, expend all of the earnings**
22 **of the coordinated care organization that exceed the financial re-**
23 **quirements of this paragraph on services designed to address health**
24 **disparities and the social determinants of health consistent with the**
25 **coordinated care organization’s community health improvement plan.**

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

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

30 “(e) [*Coordinating*] **Coordinate** the delivery of physical health care,

1 mental health and chemical dependency services, oral health care and cov-
2 ered long-term care services.

3 “(f) [*Engaging*] **Engage** community members and health care providers in
4 improving the health of the community and addressing regional, cultural,
5 socioeconomic and racial disparities in health care that exist among the co-
6 ordinated care organization’s members and in the coordinated care
7 organization’s community.

8 “(2) In addition to the criteria specified in subsection (1) of this section,
9 the authority must adopt by rule requirements for coordinated care organ-
10 izations contracting with the authority so that:

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

14 “(b) Each member has a consistent and stable relationship with a care
15 team that is responsible for comprehensive care management and service
16 delivery.

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

21 “(d) Members receive comprehensive transitional care, including appro-
22 priate follow-up, when entering and leaving an acute care facility or a long
23 term care setting.

24 “(e) Members receive assistance in navigating the health care delivery
25 system and in accessing community and social support services and statewide
26 resources, including through the use of certified health care interpreters, as
27 defined in ORS 413.550, community health workers and personal health
28 navigators who meet competency standards established by the authority un-
29 der ORS 414.665 or who are certified by the Home Care Commission under
30 ORS 410.604.

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

5 “(g) Each coordinated care organization uses health information technol-
6 ogy to link services and care providers across the continuum of care to the
7 greatest extent practicable and if financially viable.

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

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

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

18 “(k) Members have a choice of providers within the coordinated care
19 organization’s network and that providers participating in a coordinated care
20 organization:

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

23 “(B) Are educated about the integrated approach and how to access and
24 communicate within the integrated system about a patient’s treatment plan
25 and health history.

26 “(C) Emphasize prevention, healthy lifestyle choices, evidence-based
27 practices, shared decision-making and communication.

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

30 “(E) Include providers of specialty care.

1 “(F) Are selected by coordinated care organizations using universal ap-
2 plication and credentialing procedures and objective quality information and
3 are removed if the providers fail to meet objective quality standards.

4 “(G) Work together to develop best practices for culturally appropriate
5 care and service delivery to reduce waste, reduce health disparities and im-
6 prove the health and well-being of members.

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

10 “(m) Each coordinated care organization uses best practices in the man-
11 agement of finances, contracts, claims processing, payment functions and
12 provider networks.

13 “(n) Each coordinated care organization participates in the learning
14 collaborative described in ORS 413.259 (3).

15 “(o) Each coordinated care organization has a governing body that in-
16 cludes:

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

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

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

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

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

24 “(D) At least two members from the community at large, to ensure that
25 the organization’s decision-making is consistent with the values of the
26 members and the community; and

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

28 “(p) Each coordinated care organization’s governing body establishes
29 standards for publicizing the activities of the coordinated care organization
30 and the organization’s community advisory councils, as necessary, to keep

1 the community informed.

2 “(3) The authority shall consider the participation of area agencies and
3 other nonprofit agencies in the configuration of coordinated care organiza-
4 tions.

5 “(4) In selecting one or more coordinated care organizations to serve a
6 geographic area, the authority shall:

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

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

11 “(c) Allow more than one coordinated care organization to serve the ge-
12 ographic area if necessary to optimize access and choice under this sub-
13 section.

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

18 **“SECTION 5.** ORS 414.627 is amended to read:

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

22 “(a) Include representatives of the community and of each county gov-
23 ernment served by the coordinated care organization, but consumer repre-
24 sentatives must constitute a majority of the membership; and

25 “(b) Have its membership selected by a committee composed of equal
26 numbers of county representatives from each county served by the coordi-
27 nated care organization and members of the governing body of the coordi-
28 nated care organization.

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

30 “(a) Identifying and advocating for preventive care practices to be utilized

1 by the coordinated care organization;

2 “(b) Overseeing a community health assessment and adopting a commu-
3 nity health improvement plan to serve as a strategic population health and
4 health care system service plan for the community served by the coordinated
5 care organization; and

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

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

13 “(a) Analysis and development of public and private resources, capacities
14 and metrics based on ongoing community health assessment activities and
15 population health priorities;

16 “(b) Health policy;

17 “(c) System design;

18 “(d) Outcome and quality improvement;

19 “(e) Integration of service delivery; and

20 “(f) Workforce development.

21 “(4) The council shall meet at least once every three months. The council
22 shall post a report of its meetings and discussions to the website of the co-
23 ordinated care organization and other websites appropriate to keeping the
24 community informed of the council’s activities. The council, the governing
25 body of the coordinated care organization or a designee of the council or
26 governing body has discretion as to whether public comments received at
27 meetings that are open to the public will be included in the reports posted
28 to the website and, if so, which comments are appropriate for posting.

29 “(5) If the regular council meetings are not open to the public and do not
30 provide an opportunity for members of the public to provide written and oral

1 comments, the council shall hold quarterly meetings:

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

4 “(b) At which the council shall report on the activities of the coordinated
5 care organization and the council;

6 “(c) At which the council shall provide written reports on the activities
7 of the coordinated care organization; and

8 “(d) At which the council shall provide the opportunity for the public to
9 provide written or oral comments.

10 “(6) The coordinated care organization shall post to the organization’s
11 website contact information for, at a minimum, the chairperson, a member
12 of the community advisory council or a designated staff member of the or-
13 ganization.

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

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

17 “414.025. As used in this chapter and ORS chapters 411 and 413, unless
18 the context or a specially applicable statutory definition requires otherwise:

19 “(1)(a) ‘Alternative payment methodology’ means a payment other than a
20 fee-for-services payment, used by coordinated care organizations as compen-
21 sation for the provision of integrated and coordinated health care and ser-
22 vices.

23 “(b) ‘Alternative payment methodology’ includes, but is not limited to:

24 “(A) Shared savings arrangements;

25 “(B) Bundled payments; and

26 “(C) Payments based on episodes.

27 “(2) ‘Behavioral health clinician’ means:

28 “(a) A licensed psychiatrist;

29 “(b) A licensed psychologist;

30 “(c) A certified nurse practitioner with a specialty in psychiatric mental

1 health;

2 “(d) A licensed clinical social worker;

3 “(e) A licensed professional counselor or licensed marriage and family
4 therapist;

5 “(f) A certified clinical social work associate;

6 “(g) An intern or resident who is working under a board-approved super-
7 visory contract in a clinical mental health field; or

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

10 “(3) ‘Behavioral health home’ means a mental health disorder or sub-
11 stance use disorder treatment organization, as defined by the Oregon Health
12 Authority by rule, that provides integrated health care to individuals whose
13 primary diagnoses are mental health disorders or substance use disorders.

14 “(4) ‘Category of aid’ means assistance provided by the Oregon Supple-
15 mental Income Program, aid granted under ORS 411.877 to 411.896 and
16 412.001 to 412.069 or federal Supplemental Security Income payments.

17 “(5) ‘Community health worker’ means an individual who:

18 “(a) Has expertise or experience in public health;

19 “(b) Works in an urban or rural community, either for pay or as a vol-
20 unteer in association with a local health care system;

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

24 “(d) Assists members of the community to improve their health and in-
25 creases the capacity of the community to meet the health care needs of its
26 residents and achieve wellness;

27 “(e) Provides health education and information that is culturally appro-
28 priate to the individuals being served;

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

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

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

3 “(6) ‘Coordinated care organization’ means an organization meeting cri-
4 teria adopted by the Oregon Health Authority under ORS 414.625.

5 “(7) ‘Dually eligible for Medicare and Medicaid’ means, with respect to
6 eligibility for enrollment in a coordinated care organization, that an indi-
7 vidual is eligible for health services funded by Title XIX of the Social Se-
8 curity Act and is:

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

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

12 “(8) ‘Global budget’ means a total amount established prospectively by the
13 Oregon Health Authority to be paid to a coordinated care organization for
14 the delivery of, management of, access to and quality of the health care de-
15 livered to members of the coordinated care organization.

16 “(9) ‘Health insurance exchange’ or ‘exchange’ means an American Health
17 Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

18 “(10) ‘Health services’ means at least so much of each of the following
19 as are funded by the Legislative Assembly based upon the prioritized list of
20 health services compiled by the Health Evidence Review Commission under
21 ORS 414.690:

22 “(a) Services required by federal law to be included in the state’s medical
23 assistance program in order for the program to qualify for federal funds;

24 “(b) Services provided by a physician as defined in ORS 677.010, a nurse
25 practitioner certified under ORS 678.375 or other licensed practitioner within
26 the scope of the practitioner’s practice as defined by state law, and ambu-
27 lance services;

28 “(c) Prescription drugs;

29 “(d) Laboratory and X-ray services;

30 “(e) Medical equipment and supplies;

1 “(f) Mental health services;
2 “(g) Chemical dependency services;
3 “(h) Emergency dental services;
4 “(i) Nonemergency dental services;
5 “(j) Provider services, other than services described in paragraphs (a) to
6 (i), (k), (L) and (m) of this subsection, defined by federal law that may be
7 included in the state’s medical assistance program;
8 “(k) Emergency hospital services;
9 “(L) Outpatient hospital services; and
10 “(m) Inpatient hospital services.
11 “(11) ‘Income’ has the meaning given that term in ORS 411.704.
12 “(12)(a) ‘Integrated health care’ means care provided to individuals and
13 their families in a patient centered primary care home or behavioral health
14 home by licensed primary care clinicians, behavioral health clinicians and
15 other care team members, working together to address one or more of the
16 following:
17 “(A) Mental illness.
18 “(B) Substance use disorders.
19 “(C) Health behaviors that contribute to chronic illness.
20 “(D) Life stressors and crises.
21 “(E) Developmental risks and conditions.
22 “(F) Stress-related physical symptoms.
23 “(G) Preventive care.
24 “(H) Ineffective patterns of health care utilization.
25 “(b) As used in this subsection, ‘other care team members’ includes but
26 is not limited to:
27 “(A) Qualified mental health professionals or qualified mental health as-
28 sociates meeting requirements adopted by the Oregon Health Authority by
29 rule;
30 “(B) Peer wellness specialists;

1 “(C) Peer support specialists;

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

4 “(E) Personal health navigators; or

5 “(F) Other qualified individuals approved by the Oregon Health Author-
6 ity.

7 “(13) ‘Investments and savings’ means cash, securities as defined in ORS
8 59.015, negotiable instruments as defined in ORS 73.0104 and such similar
9 investments or savings as the department or the authority may establish by
10 rule that are available to the applicant or recipient to contribute toward
11 meeting the needs of the applicant or recipient.

12 “(14) ‘Medical assistance’ means so much of the medical, mental health,
13 preventive, supportive, palliative and remedial care and services as may be
14 prescribed by the authority according to the standards established pursuant
15 to ORS 414.065, including premium assistance and payments made for ser-
16 vices provided under an insurance or other contractual arrangement and
17 money paid directly to the recipient for the purchase of health services and
18 for services described in ORS 414.710.

19 “(15) ‘Medical assistance’ includes any care or services for any individual
20 who is a patient in a medical institution or any care or services for any in-
21 dividual who has attained 65 years of age or is under 22 years of age, and
22 who is a patient in a private or public institution for mental diseases. Except
23 as provided in ORS 411.439 and 411.447, ‘medical assistance’ does not include
24 care or services for a resident of a nonmedical public institution.

25 “(16) ‘Patient centered primary care home’ means a health care team or
26 clinic that is organized in accordance with the standards established by the
27 Oregon Health Authority under ORS 414.655 and that incorporates the fol-
28 lowing core attributes:

29 “(a) Access to care;

30 “(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
6 provide supportive services to a current or former consumer of mental health
7 or addiction treatment:

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

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

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

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

23 “(19) ‘Person centered care’ means care that:

24 “(a) Reflects the individual patient’s strengths and preferences;

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

27 “(c) Is based upon the patient’s goals and will assist the patient in
28 achieving the goals.

29 “(20) ‘Personal health navigator’ means an individual who provides in-
30 formation, assistance, tools and support to enable a patient to make the best

1 health care decisions in the patient’s particular circumstances and in light
2 of the patient’s needs, lifestyle, combination of conditions and desired out-
3 comes.

4 “(21) ‘Prepaid managed care health services organization’ means a man-
5 aged dental care, mental health or chemical dependency organization that
6 contracts with the authority under ORS 414.654 or with a coordinated care
7 organization on a prepaid capitated basis to provide health services to med-
8 ical assistance recipients.

9 “(22) ‘Quality measure’ means the health outcome and quality measures
10 and benchmarks identified by the Health Plan Quality Metrics Committee
11 and the metrics and scoring subcommittee in accordance with ORS 413.017
12 (4) and 414.638.

13 “(23) ‘Resources’ has the meaning given that term in ORS 411.704. For
14 eligibility purposes, ‘resources’ does not include charitable contributions
15 raised by a community to assist with medical expenses.

16 “(24) ‘**Social determinants of health**’ means the conditions in which
17 individuals are born, grow, live, work and age, including but not lim-
18 ited to food, safe housing, economic opportunities, health care, trans-
19 portation and education.

20 “**SECTION 7. Section 3 of this 2017 Act and the amendments to ORS**
21 **414.025, 414.625 and 414.627 by sections 4 to 6 of this 2017 Act apply:**

22 “(1) **To coordinated care organizations that have contracts with the**
23 **Oregon Health Authority on the effective date of this 2017 Act.**

24 “(2) **Beginning on the effective date of the next contract between**
25 **the coordinated care organization and the authority that is entered**
26 **into, amended or renewed on or after the effective date of this 2017**
27 **Act.**

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

