

At the request of Representative Cedric Hayden

**PROPOSED AMENDMENTS TO
HOUSE BILL 2834**

1 In line 2 of the printed bill, after “care” insert “; creating new provisions;
2 and amending ORS 414.625”.

3 Delete lines 4 through 16 and insert:

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

6 **“SECTION 2. (1) A hospital that by contract or affiliation with a
7 coordinated care organization serves members of the coordinated care
8 organization must provide oral health care services to an individual
9 who resides within the geographic area served by the coordinated care
10 organization if the individual:**

11 **“(a) Has family income, determined in accordance with rules
12 adopted by the Oregon Health Authority, that is at or below 250 per-
13 cent of the federal poverty guidelines;**

14 **“(b) Does not have oral health care coverage provided by:**

15 **“(A) The medical assistance program;**

16 **“(B) Employer-sponsored health insurance; or**

17 **“(C) The United States Department of Veterans Affairs; and**

18 **“(c)(A) Is a veteran; or**

19 **“(B) Is 65 years of age or older.**

20 **“(2) The cost of oral health care services provided under this section
21 shall be accounted for as a portion of a hospital’s community benefit,**

1 as defined in ORS 442.200.

2 “(3) A coordinated care organization, dental care organization or
3 hospital shall determine that an individual meets the requirements
4 specified in subsection (1) of this section before accounting for the cost
5 as a portion of the hospital’s community benefit.

6 “**SECTION 3.** ORS 414.625 is amended to read:

7 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-
8 fication criteria and requirements for a coordinated care organization and
9 shall integrate the criteria and requirements into each contract with a co-
10 ordinated care organization. Coordinated care organizations may be local,
11 community-based organizations or statewide organizations with community-
12 based participation in governance or any combination of the two. Coordi-
13 nated care organizations may contract with counties or with other public or
14 private entities to provide services to members. The authority may not con-
15 tract with only one statewide organization. A coordinated care organization
16 may be a single corporate structure or a network of providers organized
17 through contractual relationships. The criteria adopted by the authority un-
18 der this section must include, but are not limited to, the coordinated care
19 organization’s demonstrated experience and capacity for:

20 “(a) Managing financial risk and establishing financial reserves.

21 “(b) Meeting the following minimum financial requirements:

22 “(A) Maintaining restricted reserves of \$250,000 plus an amount equal to
23 50 percent of the coordinated care organization’s total actual or projected
24 liabilities above \$250,000.

25 “(B) Maintaining a net worth in an amount equal to at least five percent
26 of the average combined revenue in the prior two quarters of the partic-
27 ipating health care entities.

28 “(c) Operating within a fixed global budget.

29 “(d) Developing and implementing alternative payment methodologies that
30 are based on health care quality and improved health outcomes.

1 “(e) Coordinating the delivery of physical health care, mental health and
2 chemical dependency services, oral health care and covered long-term care
3 services.

4 “(f) Engaging community members and health care providers in improving
5 the health of the community and addressing regional, cultural, socioeconomic
6 and racial disparities in health care that exist among the coordinated care
7 organization’s members and in the coordinated care organization’s commu-
8 nity.

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

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

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

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

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

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

1 ORS 410.604.

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

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

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

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

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

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

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

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

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

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

1 “(E) Include providers of specialty care.

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

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

8 “(L) Each coordinated care organization:

9 “(A) Reports on outcome and quality measures adopted under ORS 414.638
10 [*and*];

11 “(B) Participates in the health care data reporting system established in
12 ORS 442.464 and 442.466; **and**

13 “(C) **Reports information about hospitals contracting or affiliated**
14 **with the coordinated care organization, as prescribed by the authority,**
15 **as necessary to ensure compliance with section 2 of this 2017 Act.**

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

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

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

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

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

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

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

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

30 “(D) At least two members from the community at large, to ensure that

1 the organization's decision-making is consistent with the values of the
2 members and the community; and

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

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

8 “(q) **Each hospital contracting or affiliated with a coordinated care**
9 **organization complies with the requirements of section 2 of this 2017**
10 **Act.**

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

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

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

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

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

23 “(5) On or before July 1, 2014, each coordinated care organization must
24 have a formal contractual relationship with any dental care organization
25 that serves members of the coordinated care organization in the area where
26 they reside.”

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