

Enrolled
House Bill 4018

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care)

CHAPTER

AN ACT

Relating to coordinated care organizations; creating new provisions; amending ORS 414.625 and 414.652; and declaring an emergency.

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

SECTION 1. Section 2 of this 2018 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) Meetings of a governing body of a coordinated care organization in which substantive decisions are made final must:

- (a) Be open to the public;
 - (b) Provide an opportunity for members of the public to provide written or oral testimony; and
 - (c) Include the minutes or other record of the previous meeting of the governing body.
- (2) A coordinated care organization shall give public notice, reasonably calculated to give actual notice to interested persons, of the time and place for meetings described in subsection (1) of this section.

(3) Meetings of a governing body of a coordinated care organization are not subject to ORS 192.610 to 192.690.

(4) The governing body of a coordinated care organization shall provide for the sound, video or digital recording or the taking of written minutes of all its meetings. Neither a full transcript nor a full recording of a meeting is required but the written minutes or recording must give a true reflection of the matters discussed at the meeting and the views of the participants. All minutes or recordings must be available to the public within a reasonable time after the meeting and must include at least the following information:

- (a) All members of the governing body present;
- (b) All motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition;
- (c) Unanimous votes on decisions or, if a vote is not unanimous, the results of the vote and the vote of each member by name; and
- (d) The substance of any discussion on any matter.

(5) A coordinated care organization shall make available on its website, at a minimum, the following information:

- (a) The minutes or other record of previous meetings of the governing body of the coordinated care organization; and
- (b) Contact information for:
 - (A) The chairperson of the governing body; and

(B) A member of the governing body or a staff member of the coordinated care organization responsible for providing information to the public about the activities of the coordinated care organization.

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 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 **and requirements** adopted by the authority under this section must include, but are not limited to, **a requirement that** the coordinated care *[organization's demonstrated experience and capacity for]* **organization:**

(a) **Have demonstrated experience and a capacity for** managing financial risk and establishing financial reserves.

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

(A) *[Maintaining]* **Maintain** 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]* **Maintain** 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) **Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).**

(c) *[Operating]* **Operate** within a fixed global budget and, by January 1, 2023, *[spending]* **spend** on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) *[Coordinating]* **Coordinate** the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

(f) *[Engaging]* **Engage** 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 **and requirements** 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 and qualified health care interpreters, as those terms are defined in ORS 413.550.

(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 ORS 414.766, 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 [*of which a majority of the members are persons that share in the financial risk of the organization and*] **that complies with section 2 of this 2018 Act and** that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

[(A)] **(B)** A representative of a dental care organization selected by the coordinated care organization;

[(B)] **(C)** The major components of the health care delivery system;

[(C)] **(D)** 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)] (E) 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)] (F) 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 4. ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, 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 **and requirements** adopted by the authority under this section must include, but are not limited to, **a requirement that the coordinated care [organization's demonstrated experience and capacity for] organization:**

(a) **Have demonstrated experience and a capacity for** managing financial risk and establishing financial reserves.

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

(A) [Maintaining] **Maintain** 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] **Maintain** 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) **Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).**

(c) [Operating] **Operate** within a fixed global budget and [spending] **spend** on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

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

(e) [*Coordinating*] **Coordinate** the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.

(f) [*Engaging*] **Engage** 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 **and requirements** 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 and qualified health care interpreters, as those terms are defined in ORS 413.550.

(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 ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

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(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 [*of which a majority of the members are persons that share in the financial risk of the organization and*] **that complies with section 2 of this 2018 Act and** that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

~~[(A)]~~ **(B)** A representative of a dental care organization selected by the coordinated care organization;

~~[(B)]~~ **(C)** The major components of the health care delivery system;

~~[(C)]~~ **(D)** 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)]~~ **(E)** 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)]~~ **(F)** 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 5. ORS 414.652 is amended to read:

414.652. **(1) As used in this section:**

(a) "Benefit period" means a period of time, shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(b) "Renew" means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

~~[(1)]~~ **(2)** A contract entered into between the [*Oregon Health*] authority and a coordinated care organization under ORS 414.625 (1):

(a) Shall be for a term of five years;

(b) Except as provided in subsection ~~[(3)]~~ **(4)** of this section, may not be amended more than once in each 12-month period; and

(c) May be terminated **by the authority** if a coordinated care organization fails to meet outcome and quality measures specified in the contract or is otherwise in breach of the contract.

[2] (3) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet outcome and quality measures specified in the contract prior to the termination of the contract.

[3] (4) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

(a) The authority and the coordinated care organization mutually agree to amend the contract; or

(b) Amendments are necessitated by changes in federal or state law.

[4] (5) **Except as provided in subsection (7) of this section**, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization[, *or to contracts to be renewed, including the global budget paid to the coordinated care organization under the contract*].

[5] (6) An amendment to a contract may apply retroactively only if:

(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services.

(7) No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

(8) A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection (7) of this section. Except as provided in subsections (9) and (10) of this section, a refusal to renew terminates the contract at the end of the benefit period.

(9) The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

(a) Notified each of its members and contracted providers of the termination of the contract;

(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

(c) Provided to the authority a plan for closing out its coordinated care organization business.

(10) The authority may waive compliance with the deadlines in subsections (8) and (9) of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

SECTION 6. Sections 1 and 2 of this 2018 Act and the amendments to ORS 414.625 by sections 3 and 4 of this 2018 Act become operative on January 1, 2019.

SECTION 7. This 2018 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2018 Act takes effect on its passage.

Passed by House February 20, 2018

Repassed by House March 3, 2018

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Timothy G. Sekerak, Chief Clerk of House

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Tina Kotek, Speaker of House

Passed by Senate March 1, 2018

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Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2018

Approved:

.....M,....., 2018

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2018

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Dennis Richardson, Secretary of State