

HOUSE MINORITY REPORT AMENDMENTS TO HOUSE BILL 4018

By Nonconcurring Members of COMMITTEE ON HEALTH CARE

February 16

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the line and insert “414.025,
2 414.625 and 414.652; and”.

3 In line 5, delete “Section 2” and insert “Sections 2 and 3” and delete “is” and insert “are”.

4 Delete lines 6 and 7 and insert:

5 **“SECTION 2. (1) As used in this section, ‘decision’ has the meaning given that term in**
6 **ORS 192.610.**

7 **“(2) Meetings of a governing body of a coordinated care organization in which decisions**
8 **are made final must:**

9 **“(a) Be open to the public;**

10 **“(b) Provide an opportunity for members of the public to provide written or oral testi-**
11 **mony; and**

12 **“(c) Include the minutes or other record of the previous meeting of the governing body.**

13 **“(3) A coordinated care organization shall give public notice, reasonably calculated to**
14 **give actual notice to interested persons, of the time and place for meetings described in**
15 **subsection (1) of this section.**

16 **“(4) Meetings of a governing body of a coordinated care organization are not subject to**
17 **ORS 192.610 to 192.690.**

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

24 **“(a) All members of the governing body present;**

25 **“(b) All motions, proposals, resolutions, orders, ordinances and measures proposed and**
26 **their disposition;**

27 **“(c) Unanimous votes on decisions or, if a vote is not unanimous, the results of the vote**
28 **and the vote of each member by name; and**

29 **“(d) The substance of any discussion on any matter.**

30 **“(6) A coordinated care organization shall make available on its website, at a minimum,**
31 **the following information:**

32 **“(a) The minutes or other record of previous meetings of the governing body of the co-**
33 **ordinated care organization; and**

34 **“(b) Contact information for:**

1 “(A) The chairperson of the governing body; and

2 “(B) A member of the governing body or a staff member of the coordinated care organ-
3 ization responsible for providing information to the public about the activities of the coordi-
4 nated care organization.

5 “SECTION 3. The Oregon Health Authority shall collaborate with coordinated care or-
6 ganizations to develop specific requirements for a coordinated care organization’s annual
7 investments in the social determinants of health of its members. The requirements must
8 be consistent with the requirements contained in the terms and conditions of the demon-
9 stration project approved by the Centers for Medicare and Medicaid Services regarding:

10 “(1) The incorporation of costs of health-related services into the development of the
11 global budget for each coordinated care organization; and

12 “(2) The treatment of health-related services in the calculation of a coordinated care
13 organization’s medical loss ratio and the reinvestment that is triggered by a coordinated care
14 organization’s medical loss ratio.”.

15 In line 8, delete “3” and insert “4”.

16 In line 27, after “Expend” delete the rest of the line and line 28 and insert “one percent of the
17 coordinated care organization’s global budget on investments in the social determinants of health
18 in accordance with section 3 of this 2018 Act.”.

19 On page 2, delete lines 1 through 4.

20 In line 5, delete “spending” and insert “spend”.

21 On page 4, line 9, delete “4” and insert “5”.

22 In line 29, after “Expend” delete the rest the line and lines 30 through 34 and insert “one per-
23 cent of the coordinated care organization’s global budget on investments in the social determinants
24 of health in accordance with section 3 of this 2018 Act.”.

25 In line 35, delete “spending” and insert “spend”.

26 On page 6, after line 38, insert:

27 “SECTION 6. (1) The Task Force on Sustainable Funding for Services Provided by Coordi-
28 nated Care Organizations is established.

29 “(2) The task force consists of:

30 “(a) Eight voting members appointed as follows:

31 “(A) Two members of the majority party in the Senate appointed by the President of the
32 Senate;

33 “(B) Two members of the minority party in the Senate appointed by the leader of the
34 minority party in the Senate;

35 “(C) Two members of the majority party in the House of Representatives appointed by
36 the Speaker of the House of Representatives; and

37 “(D) Two members of the minority party in the House of Representatives appointed by
38 the leader of the minority party in the House of Representatives; and

39 “(b) The following nonvoting members:

40 “(A) The Director of the Oregon Health Authority or an appointee of the director who
41 is an employee of the Oregon Health Authority;

42 “(B) The Director of the Department of Consumer and Business Services or an appointee
43 of the director who is an employee of the Department of Consumer and Business Services;

44 “(C) The Director of the Department of Revenue or an appointee of the director who is
45 an employee of the Department of Revenue;

1 “(D) One member, appointed by the Governor, from a union representing employees who
2 are engaged in public health activities; and

3 “(E) Four members, appointed by the Governor, who are licensed as or employed by any
4 of the following health care provider types that are licensed or certified in Oregon:

5 “(i) Inpatient hospital services providers.

6 “(ii) Outpatient hospital services providers.

7 “(iii) Nursing facilities.

8 “(iv) Intermediate care facilities for individuals with intellectual disabilities.

9 “(v) Physicians.

10 “(vi) Home health care service providers.

11 “(vii) Providers of prescription drugs.

12 “(viii) Managed care organizations.

13 “(ix) Ambulatory surgical centers.

14 “(x) Dental service providers.

15 “(xi) Podiatrists.

16 “(xii) Chiropractic physicians.

17 “(xiii) Providers of optometric or optician services.

18 “(xiv) Psychologists.

19 “(xv) Therapists.

20 “(xvi) Nurses.

21 “(xvii) Laboratory and medical imaging service providers.

22 “(xviii) Emergency ambulance service providers.

23 “(3) The task force shall meet at least twice monthly to create a legislative concept that
24 will ensure a stable funding source or strategy to pay the costs of services provided by co-
25 ordinated care organizations to medical assistance recipients. The task force shall present
26 the concept to the interim committees of the Legislative Assembly related to health no later
27 than December 31, 2018.

28 “(4) A majority of the voting members of the task force constitutes a quorum for the
29 transaction of business.

30 “(5) Official action by the task force requires the approval of a majority of the voting
31 members of the task force.

32 “(6) The task force shall elect one of its members to serve as chairperson.

33 “(7) If there is a vacancy for any cause, the appointing authority shall make an appoint-
34 ment to become immediately effective.

35 “(8) The task force shall meet at places specified by the chairperson or by a majority of
36 the voting members of the task force.

37 “(9) The task force may adopt rules necessary for the operation of the task force.

38 “(10) The Oregon Health Authority shall provide staff support to the task force.

39 “(11) Members of the task force who are not members of the Legislative Assembly or a
40 state agency are entitled to compensation and reimbursement as provided in ORS 292.495.

41 “(12) All agencies of state government, as defined in ORS 174.111, are directed to assist
42 the task force in the performance of the task force’s duties and, to the extent permitted by
43 laws relating to confidentiality, to furnish information and advice the members of the task
44 force consider necessary to perform their duties.

45 “SECTION 7. ORS 414.025 is amended to read:

1 “414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a spe-
2 cially applicable statutory definition requires otherwise:

3 “(1)(a) ‘Alternative payment methodology’ means a payment other than a fee-for-services pay-
4 ment, used by coordinated care organizations as compensation for the provision of integrated and
5 coordinated health care and services.

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

7 “(A) Shared savings arrangements;

8 “(B) Bundled payments; and

9 “(C) Payments based on episodes.

10 “(2) ‘Behavioral health assessment’ means an evaluation by a behavioral health clinician, in
11 person or using telemedicine, to determine a patient’s need for immediate crisis stabilization.

12 “(3) ‘Behavioral health clinician’ means:

13 “(a) A licensed psychiatrist;

14 “(b) A licensed psychologist;

15 “(c) A certified nurse practitioner with a specialty in psychiatric mental health;

16 “(d) A licensed clinical social worker;

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

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

19 “(g) An intern or resident who is working under a board-approved supervisory contract in a
20 clinical mental health field; or

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

23 “(4) ‘Behavioral health crisis’ means a disruption in an individual’s mental or emotional stability
24 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
25 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or
26 physical health.

27 “(5) ‘Behavioral health home’ means a mental health disorder or substance use disorder treat-
28 ment organization, as defined by the Oregon Health Authority by rule, that provides integrated
29 health care to individuals whose primary diagnoses are mental health disorders or substance use
30 disorders.

31 “(6) ‘Category of aid’ means assistance provided by the Oregon Supplemental Income Program,
32 aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security
33 Income payments.

34 “(7) ‘Community health worker’ means an individual who meets qualification criteria adopted
35 by the authority under ORS 414.665 and who:

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

37 “(b) Works in an urban or rural community, either for pay or as a volunteer in association with
38 a local health care system;

39 “(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
40 ences with the residents of the community where the worker serves;

41 “(d) Assists members of the community to improve their health and increases the capacity of the
42 community to meet the health care needs of its residents and achieve wellness;

43 “(e) Provides health education and information that is culturally appropriate to the individuals
44 being served;

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

1 “(g) May give peer counseling and guidance on health behaviors; and
2 “(h) May provide direct services such as first aid or blood pressure screening.
3 “(8) ‘Coordinated care organization’ means an organization meeting criteria adopted by the
4 Oregon Health Authority under ORS 414.625.
5 “(9) ‘Dually eligible for Medicare and Medicaid’ means, with respect to eligibility for enrollment
6 in a coordinated care organization, that an individual is eligible for health services funded by Title
7 XIX of the Social Security Act and is:
8 “(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or
9 “(b) Enrolled in Part B of Title XVIII of the Social Security Act.
10 “(10)(a) ‘Family support specialist’ means an individual who meets qualification criteria adopted
11 by the authority under ORS 414.665 and who provides supportive services to and has experience
12 parenting a child who:
13 “(A) Is a current or former consumer of mental health or addiction treatment; or
14 “(B) Is facing or has faced difficulties in accessing education, health and wellness services due
15 to a mental health or behavioral health barrier.
16 “(b) A ‘family support specialist’ may be a peer wellness specialist or a peer support specialist.
17 “(11) ‘Global budget’ means a total amount established prospectively by the Oregon Health Au-
18 thority to be paid to a coordinated care organization for the delivery of, management of, access to
19 and quality of the health care delivered to members of the coordinated care organization.
20 “(12) ‘Health insurance exchange’ or ‘exchange’ means an American Health Benefit Exchange
21 described in 42 U.S.C. 18031, 18032, 18033 and 18041.
22 “(13) ‘Health services’ means at least so much of each of the following as are funded by the
23 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-
24 dence Review Commission under ORS 414.690:
25 “(a) Services required by federal law to be included in the state’s medical assistance program
26 in order for the program to qualify for federal funds;
27 “(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified
28 under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of
29 the practitioner’s practice as defined by state law, and ambulance services;
30 “(c) Prescription drugs;
31 “(d) Laboratory and X-ray services;
32 “(e) Medical equipment and supplies;
33 “(f) Mental health services;
34 “(g) Chemical dependency services;
35 “(h) Emergency dental services;
36 “(i) Nonemergency dental services;
37 “(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of
38 this subsection, defined by federal law that may be included in the state’s medical assistance pro-
39 gram;
40 “(k) Emergency hospital services;
41 “(L) Outpatient hospital services; and
42 “(m) Inpatient hospital services.
43 “(14) ‘Income’ has the meaning given that term in ORS 411.704.
44 “(15)(a) ‘Integrated health care’ means care provided to individuals and their families in a pa-
45 tient centered primary care home or behavioral health home by licensed primary care clinicians,

1 behavioral health clinicians and other care team members, working together to address one or more
2 of the following:

3 “(A) Mental illness.

4 “(B) Substance use disorders.

5 “(C) Health behaviors that contribute to chronic illness.

6 “(D) Life stressors and crises.

7 “(E) Developmental risks and conditions.

8 “(F) Stress-related physical symptoms.

9 “(G) Preventive care.

10 “(H) Ineffective patterns of health care utilization.

11 “(b) As used in this subsection, ‘other care team members’ includes but is not limited to:

12 “(A) Qualified mental health professionals or qualified mental health associates meeting re-
13 quirements adopted by the Oregon Health Authority by rule;

14 “(B) Peer wellness specialists;

15 “(C) Peer support specialists;

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

17 “(E) Personal health navigators; or

18 “(F) Other qualified individuals approved by the Oregon Health Authority.

19 “(16) ‘Investments and savings’ means cash, securities as defined in ORS 59.015, negotiable in-
20 struments as defined in ORS 73.0104 and such similar investments or savings as the department or
21 the authority may establish by rule that are available to the applicant or recipient to contribute
22 toward meeting the needs of the applicant or recipient.

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

28 “(18) ‘Medical assistance’ includes any care or services for any individual who is a patient in
29 a medical institution or any care or services for any individual who has attained 65 years of age
30 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-
31 eases. Except as provided in ORS 411.439 and 411.447, ‘medical assistance’ does not include care or
32 services for a resident of a nonmedical public institution.

33 “(19) ‘Patient centered primary care home’ means a health care team or clinic that is organized
34 in accordance with the standards established by the Oregon Health Authority under ORS 414.655
35 and that incorporates the following core attributes:

36 “(a) Access to care;

37 “(b) Accountability to consumers and to the community;

38 “(c) Comprehensive whole person care;

39 “(d) Continuity of care;

40 “(e) Coordination and integration of care; and

41 “(f) Person and family centered care.

42 “(20) ‘Peer support specialist’ means any of the following individuals who meet qualification
43 criteria adopted by the authority under ORS 414.665 and who provide supportive services to a cur-
44 rent or former consumer of mental health or addiction treatment:

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

1 “(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from
2 an addiction disorder.

3 “(21) ‘Peer wellness specialist’ means an individual who meets qualification criteria adopted by
4 the authority under ORS 414.665 and who is responsible for assessing mental health and substance
5 use disorder service and support needs of a member of a coordinated care organization through
6 community outreach, assisting members with access to available services and resources, addressing
7 barriers to services and providing education and information about available resources for individ-
8 uals with mental health or substance use disorders in order to reduce stigma and discrimination
9 toward consumers of mental health and substance use disorder services and to assist the member
10 in creating and maintaining recovery, health and wellness.

11 “(22) ‘Person centered care’ means care that:

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

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

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

16 “(23) ‘Personal health navigator’ means an individual who meets qualification criteria adopted
17 by the authority under ORS 414.665 and who provides information, assistance, tools and support to
18 enable a patient to make the best health care decisions in the patient’s particular circumstances and
19 in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes.

20 “(24) ‘Prepaid managed care health services organization’ means a managed dental care, mental
21 health or chemical dependency organization that contracts with the authority under ORS 414.654
22 or with a coordinated care organization on a prepaid capitated basis to provide health services to
23 medical assistance recipients.

24 “(25) ‘Quality measure’ means the health outcome and quality measures and benchmarks identi-
25 fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in
26 accordance with ORS 413.017 (4) and 414.638.

27 “(26) ‘Resources’ has the meaning given that term in ORS 411.704. For eligibility purposes, ‘re-
28 sources’ does not include charitable contributions raised by a community to assist with medical ex-
29 penses.

30 “(27) **‘Social determinants of health’ means the conditions into which individuals are born
31 and in which individuals grow, live, work and age, including but not limited to:**

32 **“(a) Housing;**

33 **“(b) Education;**

34 **“(c) Criminal justice;**

35 **“(d) Employment opportunities;**

36 **“(e) Neighborhood environment; and**

37 **“(f) Transportation.**

38 “[~~(27)~~(a)] (28)(a) ‘Youth support specialist’ means an individual who meets qualification criteria
39 adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides
40 supportive services to an individual who:

41 “(A) Is not older than 30 years of age; and

42 “(B)(i) Is a current or former consumer of mental health or addiction treatment; or

43 “(ii) Is facing or has faced difficulties in accessing education, health and wellness services due
44 to a mental health or behavioral health barrier.

45 “(b) A ‘youth support specialist’ may be a peer wellness specialist or a peer support specialist.

1 “**SECTION 8.** Section 6 of this 2018 Act is repealed on December 31, 2019.

2 “**SECTION 9.** ORS 414.652 is amended to read:

3 “414.652. (1) As used in this section:

4 “(a) ‘Benefit period’ means a period of time, shorter than the five-year contract term,
5 for which specific terms and conditions in a contract between a coordinated care organiza-
6 tion and the Oregon Health Authority are in effect.

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

9 “[(1)] (2) A contract entered into between the [*Oregon Health*] authority and a coordinated care
10 organization under ORS 414.625 (1):

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

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

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

16 “[(2)] (3) This section does not prohibit the authority from allowing a coordinated care organ-
17 ization a reasonable amount of time in which to cure any failure to meet outcome and quality
18 measures specified in the contract prior to the termination of the contract.

19 “[(3)] (4) A contract entered into between the authority and a coordinated care organization
20 may be amended more than once in each 12-month period if:

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

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

24 “[(4)] (5) **Except as provided in subsection (7) of this section**, the authority must give a co-
25 ordinated care organization at least 60 days’ advance notice of any amendments the authority pro-
26 poses to existing contracts between the authority and the coordinated care organization[, *or to*
27 *contracts to be renewed, including the global budget paid to the coordinated care organization under*
28 *the contract*].

29 “[(5)] (6) An amendment to a contract may apply retroactively only if:

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

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

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

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

44 “(9) **The authority may require a contract to remain in force into the next benefit period**
45 **and be amended as proposed by the authority until 90 days after the coordinated care or-**

1 **ganization has, in accordance with criteria prescribed by the authority:**
2 **“(a) Notified each of its members and contracted providers of the termination of the**
3 **contract;**
4 **“(b) Provided to the authority a plan to transition its members to another coordinated**
5 **care organization; and**
6 **“(c) Provided to the authority a plan for closing out its coordinated care organization**
7 **business.**
8 **“(10) The authority may waive compliance with the deadlines in subsections (8) and (9)**
9 **of this section if the Director of the Oregon Health Authority finds that the waiver of the**
10 **deadlines is consistent with the effective and efficient administration of the medical assist-**
11 **ance program and the protection of medical assistance recipients.”.**

12 In line 39, delete “5” and insert “10”.

13 /s/ Denyc Boles
14 Representative

15 /s/ Knute Buehler
16 Representative

17 /s/ Cedric Hayden
18 Representative

19 /s/ Bill Kennemer
20 Representative

21 _____
22