

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)

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**.

Makes governing body of coordinated care organization subject to Oregon's public meetings law. Allows Oregon Health Authority to contract with only one statewide coordinated care organization. Requires expenditure of portion of coordinated care organization's annual net income or reserves on services designed to address health disparities and social determinants of health. Modifies composition of coordinated care organization governing body.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to coordinated care organizations; creating new provisions; amending ORS 414.625; and
3 declaring an emergency.

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

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

6 **SECTION 2. ORS 192.610 to 192.690 apply to all meetings of a governing body of a coordi-**
7 **dated care organization.**

8 **SECTION 3. ORS 414.625 is amended to read:**

9 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
10 quirements for a coordinated care organization and shall integrate the criteria and requirements
11 into each contract with a coordinated care organization. Coordinated care organizations may be
12 local, community-based organizations or statewide organizations with community-based participation
13 in governance or any combination of the two. Coordinated care organizations may contract with
14 counties or with other public or private entities to provide services to members. [*The authority may*
15 *not contract with only one statewide organization.*] A coordinated care organization may be a single
16 corporate structure or a network of providers organized through contractual relationships. The cri-
17 teria **and requirements** adopted by the authority under this section must include, but are not lim-
18 ited to, **a requirement that** the coordinated care [*organization's demonstrated experience and*
19 *capacity for*] **organization:**

20 (a) **Have demonstrated experience and a capacity for** managing financial risk and establish-
21 ing financial reserves.

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

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

25 (B) [*Maintaining*] **Maintain** a net worth in an amount equal to at least five percent of the av-
26 erage combined revenue in the prior two quarters of the participating health care entities.

27 (C) **Expend a portion of the annual net income or reserves of the coordinated care or-**
28 **ganization that exceed the financial requirements specified in this paragraph on services**

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.

1 **designed to address health disparities and the social determinants of health consistent with**
2 **the coordinated care organization's community health improvement plan and transformation**
3 **plan and the terms and conditions of the Medicaid demonstration project under section 1115**
4 **of the Social Security Act (42 U.S.C. 1315).**

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

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

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

13 (f) [*Engaging*] **Engage** community members and health care providers in improving the health
14 of the community and addressing regional, cultural, socioeconomic and racial disparities in health
15 care that exist among the coordinated care organization's members and in the coordinated care
16 organization's community.

17 (2) In addition to the criteria **and requirements** specified in subsection (1) of this section, the
18 authority must adopt by rule requirements for coordinated care organizations contracting with the
19 authority so that:

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

22 (b) Each member has a consistent and stable relationship with a care team that is responsible
23 for comprehensive care management and service delivery.

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

28 (d) Members receive comprehensive transitional care, including appropriate follow-up, when enter-
29 ing and leaving an acute care facility or a long term care setting.

30 (e) Members receive assistance in navigating the health care delivery system and in accessing
31 community and social support services and statewide resources, including through the use of certi-
32 fied health care interpreters and qualified health care interpreters, as those terms are defined in
33 ORS 413.550.

34 (f) Services and supports are geographically located as close to where members reside as possi-
35 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
36 communities and underserved populations.

37 (g) Each coordinated care organization uses health information technology to link services and
38 care providers across the continuum of care to the greatest extent practicable and if financially vi-
39 able.

40 (h) Each coordinated care organization complies with the safeguards for members described in
41 ORS 414.635.

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

44 (j) Each coordinated care organization prioritizes working with members who have high health
45 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those

1 members in accessing and managing appropriate preventive, health, remedial and supportive care
 2 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
 3 gency room visits and hospital admissions.

4 (k) Members have a choice of providers within the coordinated care organization’s network and
 5 that providers participating in a coordinated care organization:

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

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

10 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
 11 making and communication.

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

13 (E) Include providers of specialty care.

14 (F) Are selected by coordinated care organizations using universal application and credentialing
 15 procedures and objective quality information and are removed if the providers fail to meet objective
 16 quality standards.

17 (G) Work together to develop best practices for culturally appropriate care and service delivery
 18 to reduce waste, reduce health disparities and improve the health and well-being of members.

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

22 (m) Each coordinated care organization uses best practices in the management of finances,
 23 contracts, claims processing, payment functions and provider networks.

24 (n) Each coordinated care organization participates in the learning collaborative described in
 25 ORS 413.259 (3).

26 (o) Each coordinated care organization has a governing body [*of which a majority of the members*
 27 *are persons that share in the financial risk of the organization and*] that includes:

28 **(A) At least one member representing persons that share in the financial risk of the or-**
 29 **ganization;**

30 [(A)] **(B)** A representative of a dental care organization selected by the coordinated care or-
 31 ganization;

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

33 [(C)] **(D)** At least two health care providers in active practice, including:

34 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
 35 678.375, whose area of practice is primary care; and

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

37 [(D)] **(E)** At least two members from the community at large, to ensure that the organization’s
 38 decision-making is consistent with the values of the members and the community; and

39 [(E)] **(F)** At least one member of the community advisory council.

40 (p) Each coordinated care organization’s governing body establishes standards for publicizing
 41 the activities of the coordinated care organization and the organization’s community advisory
 42 councils, as necessary, to keep the community informed.

43 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
 44 in the configuration of coordinated care organizations.

45 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-

1 thority shall:

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

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

4 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
5 to optimize access and choice under this subsection.

6 (5) *[On or before July 1, 2014,]* Each coordinated care organization must have a formal contrac-
7 tual relationship with any dental care organization that serves members of the coordinated care
8 organization in the area where they reside.

9 **SECTION 4.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, is
10 amended to read:

11 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
12 quirements for a coordinated care organization and shall integrate the criteria and requirements
13 into each contract with a coordinated care organization. Coordinated care organizations may be
14 local, community-based organizations or statewide organizations with community-based participation
15 in governance or any combination of the two. Coordinated care organizations may contract with
16 counties or with other public or private entities to provide services to members. *[The authority may*
17 *not contract with only one statewide organization.]* A coordinated care organization may be a single
18 corporate structure or a network of providers organized through contractual relationships. The cri-
19 teria **and requirements** adopted by the authority under this section must include, but are not lim-
20 ited to, **a requirement that** the coordinated care *[organization's demonstrated experience and*
21 *capacity for]* **organization:**

22 (a) **Have demonstrated experience and a capacity for** managing financial risk and establish-
23 ing financial reserves.

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

25 (A) *[Maintaining]* **Maintain** restricted reserves of \$250,000 plus an amount equal to 50 percent
26 of the coordinated care organization's total actual or projected liabilities above \$250,000.

27 (B) *[Maintaining]* **Maintain** a net worth in an amount equal to at least five percent of the av-
28 erage combined revenue in the prior two quarters of the participating health care entities.

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

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

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

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

43 (f) *[Engaging]* **Engage** community members and health care providers in improving the health
44 of the community and addressing regional, cultural, socioeconomic and racial disparities in health
45 care that exist among the coordinated care organization's members and in the coordinated care

1 organization's community.

2 (2) In addition to the criteria **and requirements** specified in subsection (1) of this section, the
 3 authority must adopt by rule requirements for coordinated care organizations contracting with the
 4 authority so that:

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

7 (b) Each member has a consistent and stable relationship with a care team that is responsible
 8 for comprehensive care management and service delivery.

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

13 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
 14 tering and leaving an acute care facility or a long term care setting.

15 (e) Members receive assistance in navigating the health care delivery system and in accessing
 16 community and social support services and statewide resources, including through the use of certi-
 17 fied health care interpreters and qualified health care interpreters, as those terms are defined in
 18 ORS 413.550.

19 (f) Services and supports are geographically located as close to where members reside as possi-
 20 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
 21 communities and underserved populations.

22 (g) Each coordinated care organization uses health information technology to link services and
 23 care providers across the continuum of care to the greatest extent practicable and if financially vi-
 24 able.

25 (h) Each coordinated care organization complies with the safeguards for members described in
 26 ORS 414.635.

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

29 (j) Each coordinated care organization prioritizes working with members who have high health
 30 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
 31 members in accessing and managing appropriate preventive, health, remedial and supportive care
 32 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
 33 gency room visits and hospital admissions.

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 35 that providers participating in a coordinated care organization:

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38 (B) Are educated about the integrated approach and how to access and communicate within the
 39 integrated system about a patient's treatment plan and health history.

40 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
 41 making and communication.

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

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44 (F) Are selected by coordinated care organizations using universal application and credentialing
 45 procedures and objective quality information and are removed if the providers fail to meet objective

1 quality standards.

2 (G) Work together to develop best practices for culturally appropriate care and service delivery
3 to reduce waste, reduce health disparities and improve the health and well-being of members.

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

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14 **ganization;**

15 [(A)] **(B)** A representative of a dental care organization selected by the coordinated care or-
16 ganization;

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

18 [(C)] **(D)** At least two health care providers in active practice, including:

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20 678.375, whose area of practice is primary care; and

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22 [(D)] **(E)** At least two members from the community at large, to ensure that the organization's
23 decision-making is consistent with the values of the members and the community; and

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25 (p) Each coordinated care organization's governing body establishes standards for publicizing
26 the activities of the coordinated care organization and the organization's community advisory
27 councils, as necessary, to keep the community informed.

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29 in the configuration of coordinated care organizations.

30 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
31 thority shall:

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

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

34 (c) Allow more than one coordinated care organization to serve the geographic area if necessary
35 to optimize access and choice under this subsection.

36 (5) [*On or before July 1, 2014,*] Each coordinated care organization must have a formal contrac-
37 tual relationship with any dental care organization that serves members of the coordinated care
38 organization in the area where they reside.

39 **SECTION 5. This 2018 Act being necessary for the immediate preservation of the public**
40 **peace, health and safety, an emergency is declared to exist, and this 2018 Act takes effect**
41 **on its passage.**

42