

Minority Report
A-Engrossed
House Bill 4018

Ordered by the House February 16
Including House Minority Report Amendments dated February 16

Sponsored by nonconcurring members of the House Committee on Health Care: Representatives BOLES, BUEHLER, HAYDEN, KENNEMER

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.

[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 meetings of governing body of coordinated care organization in which decisions are made final to be open to public and to take public testimony. Requires coordinated care organization to record all meetings of governing body in sound, video, digital or written format and make record available on coordinated care organization's website. Requires coordinated care organization to provide contact information for chairperson of governing body and member of governing body or designated staff person.

Directs Oregon Health Authority to collaborate with coordinated care organizations to develop specific requirements for coordinated care organization investments in social determinants of health.

Requires expenditure of portion of coordinated care organization's *[annual net income or reserves on services designed to address health disparities and]* **global budget on investments in social determinants of health.** Modifies composition of coordinated care organization governing body.

Establishes new requirements for contracts between authority and coordinated care organizations. Requires coordinated care organization to provide advance notice of intent not to renew contract to authority and, under certain circumstances, to members and providers.

Establishes Task Force on Sustainable Funding for Services Provided by Coordinated Care Organizations to create legislative concept to ensure stable funding source or strategy to pay costs of services provided to medical assistance recipients by coordinated care organizations. Specifies membership and duties. Requires task force to report on concept to interim committees of Legislative Assembly related to health by December 31, 2018. Sunsets task force on December 31, 2019.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; amending ORS 414.025, 414.625 and 414.652; and declaring an emergency.

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

SECTION 1. Sections 2 and 3 of this 2018 Act are added to and made a part of ORS chapter 414.

SECTION 2. (1) As used in this section, "decision" has the meaning given that term in ORS 192.610.

(2) Meetings of a governing body of a coordinated care organization in which 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

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

2 (3) A coordinated care organization shall give public notice, reasonably calculated to give
3 actual notice to interested persons, of the time and place for meetings described in sub-
4 section (1) of this section.

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

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

13 (a) All members of the governing body present;

14 (b) All motions, proposals, resolutions, orders, ordinances and measures proposed and
15 their disposition;

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

18 (d) The substance of any discussion on any matter.

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

21 (a) The minutes or other record of previous meetings of the governing body of the coor-
22 dinated care organization; and

23 (b) Contact information for:

24 (A) The chairperson of the governing body; and

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

28 **SECTION 3.** The Oregon Health Authority shall collaborate with coordinated care or-
29 ganizations to develop specific requirements for a coordinated care organization's annual
30 investments in the social determinants of health of its members. The requirements must be
31 consistent with the requirements contained in the terms and conditions of the demonstration
32 project approved by the Centers for Medicare and Medicaid Services regarding:

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

35 (2) The treatment of health-related services in the calculation of a coordinated care
36 organization's medical loss ratio and the reinvestment that is triggered by a coordinated care
37 organization's medical loss ratio.

38 **SECTION 4.** ORS 414.625 is amended to read:

39 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
40 quirements for a coordinated care organization and shall integrate the criteria and requirements
41 into each contract with a coordinated care organization. Coordinated care organizations may be
42 local, community-based organizations or statewide organizations with community-based participation
43 in governance or any combination of the two. Coordinated care organizations may contract with
44 counties or with other public or private entities to provide services to members. [*The authority may*
45 *not contract with only one statewide organization.*] A coordinated care organization may be a single

1 corporate structure or a network of providers organized through contractual relationships. The cri-
2 teria **and requirements** adopted by the authority under this section must include, but are not lim-
3 ited to, **a requirement that** the coordinated care [*organization's demonstrated experience and*
4 *capacity for*] **organization:**

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

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

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

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

12 (C) **Expend one percent of the coordinated care organization's global budget on invest-**
13 **ments in the social determinants of health in accordance with section 3 of this 2018 Act.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (k) Members have a choice of providers within the coordinated care organization's network and
14 that providers participating in a coordinated care organization:

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

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

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

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

22 (E) Include providers of specialty care.

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

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

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

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

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

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

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

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

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

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

43 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
44 678.375, whose area of practice is primary care; and

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

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

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

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

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

9 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-
10 thORITY shall:

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

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

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

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

18 **SECTION 5.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, is
19 amended to read:

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

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

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

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

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

38 (C) **Expend one percent of the coordinated care organization's global budget on invest-**
39 **ments in the social determinants of health in accordance with section 3 of this 2018 Act.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 (k) Members have a choice of providers within the coordinated care organization's network and
40 that providers participating in a coordinated care organization:

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

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

45 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-

1 making and communication.

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

3 (E) Include providers of specialty care.

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

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

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

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

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

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

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

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

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

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

24 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
25 678.375, whose area of practice is primary care; and

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

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

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

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

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

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

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

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

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

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

44 **SECTION 6. (1) The Task Force on Sustainable Funding for Services Provided by Coor-**
45 **dated Care Organizations is established.**

- 1 **(2) The task force consists of:**
2 **(a) Eight voting members appointed as follows:**
3 **(A) Two members of the majority party in the Senate appointed by the President of the**
4 **Senate;**
5 **(B) Two members of the minority party in the Senate appointed by the leader of the mi-**
6 **nority party in the Senate;**
7 **(C) Two members of the majority party in the House of Representatives appointed by the**
8 **Speaker of the House of Representatives; and**
9 **(D) Two members of the minority party in the House of Representatives appointed by the**
10 **leader of the minority party in the House of Representatives; and**
11 **(b) The following nonvoting members:**
12 **(A) The Director of the Oregon Health Authority or an appointee of the director who is**
13 **an employee of the Oregon Health Authority;**
14 **(B) The Director of the Department of Consumer and Business Services or an appointee**
15 **of the director who is an employee of the Department of Consumer and Business Services;**
16 **(C) The Director of the Department of Revenue or an appointee of the director who is**
17 **an employee of the Department of Revenue;**
18 **(D) One member, appointed by the Governor, from a union representing employees who**
19 **are engaged in public health activities; and**
20 **(E) Four members, appointed by the Governor, who are licensed as or employed by any**
21 **of the following health care provider types that are licensed or certified in Oregon:**
22 **(i) Inpatient hospital services providers.**
23 **(ii) Outpatient hospital services providers.**
24 **(iii) Nursing facilities.**
25 **(iv) Intermediate care facilities for individuals with intellectual disabilities.**
26 **(v) Physicians.**
27 **(vi) Home health care service providers.**
28 **(vii) Providers of prescription drugs.**
29 **(viii) Managed care organizations.**
30 **(ix) Ambulatory surgical centers.**
31 **(x) Dental service providers.**
32 **(xi) Podiatrists.**
33 **(xii) Chiropractic physicians.**
34 **(xiii) Providers of optometric or optician services.**
35 **(xiv) Psychologists.**
36 **(xv) Therapists.**
37 **(xvi) Nurses.**
38 **(xvii) Laboratory and medical imaging service providers.**
39 **(xviii) Emergency ambulance service providers.**
40 **(3) The task force shall meet at least twice monthly to create a legislative concept that**
41 **will ensure a stable funding source or strategy to pay the costs of services provided by co-**
42 **ordinated care organizations to medical assistance recipients. The task force shall present**
43 **the concept to the interim committees of the Legislative Assembly related to health no later**
44 **than December 31, 2018.**
45 **(4) A majority of the voting members of the task force constitutes a quorum for the**

1 **transaction of business.**

2 **(5) Official action by the task force requires the approval of a majority of the voting**
3 **members of the task force.**

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

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

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

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

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

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

13 **(12) All agencies of state government, as defined in ORS 174.111, are directed to assist**
14 **the task force in the performance of the task force's duties and, to the extent permitted by**
15 **laws relating to confidentiality, to furnish information and advice the members of the task**
16 **force consider necessary to perform their duties.**

17 **SECTION 7.** ORS 414.025 is amended to read:

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

20 (1)(a) "Alternative payment methodology" means a payment other than a fee-for-services pay-
21 ment, used by coordinated care organizations as compensation for the provision of integrated and
22 coordinated health care and services.

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 assessment" means an evaluation by a behavioral health clinician, in
28 person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

29 (3) "Behavioral health clinician" means:

30 (a) A licensed psychiatrist;

31 (b) A licensed psychologist;

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

33 (d) A licensed clinical social worker;

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

35 (f) A certified clinical social work associate;

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

38 (h) Any other clinician whose authorized scope of practice includes mental health diagnosis and
39 treatment.

40 (4) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability
41 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
42 partment or admission to a hospital to prevent a serious deterioration in the individual's mental or
43 physical health.

44 (5) "Behavioral health home" means a mental health disorder or substance use disorder treat-
45 ment organization, as defined by the Oregon Health Authority by rule, that provides integrated

1 health care to individuals whose primary diagnoses are mental health disorders or substance use
2 disorders.

3 (6) “Category of aid” means assistance provided by the Oregon Supplemental Income Program,
4 aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security
5 Income payments.

6 (7) “Community health worker” means an individual who meets qualification criteria adopted
7 by the authority under ORS 414.665 and who:

8 (a) Has expertise or experience in public health;

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

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

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

15 (e) Provides health education and information that is culturally appropriate to the individuals
16 being served;

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

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

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

20 (8) “Coordinated care organization” means an organization meeting criteria adopted by the
21 Oregon Health Authority under ORS 414.625.

22 (9) “Dually eligible for Medicare and Medicaid” means, with respect to eligibility for enrollment
23 in a coordinated care organization, that an individual is eligible for health services funded by Title
24 XIX of the Social Security Act and is:

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

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

27 (10)(a) “Family support specialist” means an individual who meets qualification criteria adopted
28 by the authority under ORS 414.665 and who provides supportive services to and has experience
29 parenting a child who:

30 (A) Is a current or former consumer of mental health or addiction treatment; or

31 (B) Is facing or has faced difficulties in accessing education, health and wellness services due
32 to a mental health or behavioral health barrier.

33 (b) A “family support specialist” may be a peer wellness specialist or a peer support specialist.

34 (11) “Global budget” means a total amount established prospectively by the Oregon Health Au-
35 thority to be paid to a coordinated care organization for the delivery of, management of, access to
36 and quality of the health care delivered to members of the coordinated care organization.

37 (12) “Health insurance exchange” or “exchange” means an American Health Benefit Exchange
38 described in 42 U.S.C. 18031, 18032, 18033 and 18041.

39 (13) “Health services” means at least so much of each of the following as are funded by the
40 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-
41 dence Review Commission under ORS 414.690:

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

44 (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified
45 under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of

1 the practitioner's practice as defined by state law, and ambulance services;

2 (c) Prescription drugs;

3 (d) Laboratory and X-ray services;

4 (e) Medical equipment and supplies;

5 (f) Mental health services;

6 (g) Chemical dependency services;

7 (h) Emergency dental services;

8 (i) Nonemergency dental services;

9 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of
10 this subsection, defined by federal law that may be included in the state's medical assistance pro-
11 gram;

12 (k) Emergency hospital services;

13 (L) Outpatient hospital services; and

14 (m) Inpatient hospital services.

15 (14) "Income" has the meaning given that term in ORS 411.704.

16 (15)(a) "Integrated health care" means care provided to individuals and their families in a pa-
17 tient centered primary care home or behavioral health home by licensed primary care clinicians,
18 behavioral health clinicians and other care team members, working together to address one or more
19 of the following:

20 (A) Mental illness.

21 (B) Substance use disorders.

22 (C) Health behaviors that contribute to chronic illness.

23 (D) Life stressors and crises.

24 (E) Developmental risks and conditions.

25 (F) Stress-related physical symptoms.

26 (G) Preventive care.

27 (H) Ineffective patterns of health care utilization.

28 (b) As used in this subsection, "other care team members" includes but is not limited to:

29 (A) Qualified mental health professionals or qualified mental health associates meeting require-
30 ments adopted by the Oregon Health Authority by rule;

31 (B) Peer wellness specialists;

32 (C) Peer support specialists;

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

34 (E) Personal health navigators; or

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

36 (16) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable in-
37 struments as defined in ORS 73.0104 and such similar investments or savings as the department or
38 the authority may establish by rule that are available to the applicant or recipient to contribute
39 toward meeting the needs of the applicant or recipient.

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

45 (18) "Medical assistance" includes any care or services for any individual who is a patient in

1 a medical institution or any care or services for any individual who has attained 65 years of age
2 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-
3 eases. Except as provided in ORS 411.439 and 411.447, “medical assistance” does not include care
4 or services for a resident of a nonmedical public institution.

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

- 8 (a) Access to care;
- 9 (b) Accountability to consumers and to the community;
- 10 (c) Comprehensive whole person care;
- 11 (d) Continuity of care;
- 12 (e) Coordination and integration of care; and
- 13 (f) Person and family centered care.

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

- 17 (a) An individual who is a current or former consumer of mental health treatment; or
- 18 (b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from
19 an addiction disorder.

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

28 (22) “Person centered care” means care that:

- 29 (a) Reflects the individual patient’s strengths and preferences;
- 30 (b) Reflects the clinical needs of the patient as identified through an individualized assessment;
31 and
- 32 (c) Is based upon the patient’s goals and will assist the patient in achieving the goals.

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

37 (24) “Prepaid managed care health services organization” means a managed dental care, mental
38 health or chemical dependency organization that contracts with the authority under ORS 414.654
39 or with a coordinated care organization on a prepaid capitated basis to provide health services to
40 medical assistance recipients.

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

44 (26) “Resources” has the meaning given that term in ORS 411.704. For eligibility purposes, “re-
45 sources” does not include charitable contributions raised by a community to assist with medical

1 expenses.

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

- 4 **(a) Housing;**
- 5 **(b) Education;**
- 6 **(c) Criminal justice;**
- 7 **(d) Employment opportunities;**
- 8 **(e) Neighborhood environment; and**
- 9 **(f) Transportation.**

10 [(27)(a)] **(28)(a)** “Youth support specialist” means an individual who meets qualification criteria
11 adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides
12 supportive services to an individual who:

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

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

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

17 (b) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

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

19 **SECTION 9. ORS 414.652 is amended to read:**

20 **414.652. (1) As used in this section:**

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

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

26 [(1)] **(2)** A contract entered into between the [*Oregon Health*] authority and a coordinated care
27 organization under ORS 414.625 (1):

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

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

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

33 [(2)] **(3)** This section does not prohibit the authority from allowing a coordinated care organ-
34 ization a reasonable amount of time in which to cure any failure to meet outcome and quality
35 measures specified in the contract prior to the termination of the contract.

36 [(3)] **(4)** A contract entered into between the authority and a coordinated care organization may
37 be amended more than once in each 12-month period if:

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

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

41 [(4)] **(5) Except as provided in subsection (7) of this section,** the authority must give a co-
42 ordinated care organization at least 60 days’ advance notice of any amendments the authority pro-
43 poses to existing contracts between the authority and the coordinated care organization[, or to
44 contracts to be renewed, including the global budget paid to the coordinated care organization under
45 the contract].

1 ~~[(5)]~~ **(6)** An amendment to a contract may apply retroactively only if:

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

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

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

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

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

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

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

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

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

29 **SECTION 10. This 2018 Act being necessary for the immediate preservation of the public**
30 **peace, health and safety, an emergency is declared to exist, and this 2018 Act takes effect**
31 **on its passage.**

32