House Bill 4136
Sponsored by Representative BUEHLER (Presession filed.)

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.

Requires coordinated care organizations to annually report to Oregon Health Authority specified financial information.

Requires authority to collaborate with coordinated care organizations to develop plan for full implementation of alternative payment methodologies and to develop metrics for investments in social determinants of health.

Requires authority to develop plan to reimburse costs of at least 85 percent of services using alternative payment methodologies.

Requires authority to establish structure for collaboration between coordinated care organizations and community mental health programs in each geographical region to improve coordination of behavioral health services.

Repeals sunset on Central Oregon Health Council.

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.

A BILL FOR AN ACT
Relating to health care; creating new provisions; amending ORS 414.625; and repealing section 19, chapter 418, Oregon Laws 2011.

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

SECTION 1. Sections 2 to 5 of this 2018 Act are added to and made a part of ORS chapter 414.

SECTION 2. Coordinated care organizations shall report annually to the Oregon Health Authority financial information prescribed by the authority that discloses each coordinated care organization’s profit margin, medical and nonmedical costs and investments and payments made to partner organizations.

SECTION 3. The Oregon Health Authority shall collaborate with all coordinated care organizations to develop a plan for the full implementation of alternative payment methodologies. The plan must:

(1) Describe how the authority, coordinated care organizations and contracted providers will provide at least 85 percent of the reimbursements for services using alternative payment methodologies, in accordance with ORS 414.653, by December 31, 2023;

(2) Provide a broad definition of alternative payment methodologies;

(3) Allow for a phased-in implementation over the term of a coordinated care organization's contract; and

(4) Align with the methodology and calculations for alternative payment models developed by the Center for Medicare and Medicaid Innovation.

SECTION 4. (1) As used in this section, “social determinants of health” means the conditions into which individuals are born and in which individuals grow, live, work and age, including but not limited to:

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.

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(a) Housing;
(b) Education;
(c) Criminal justice;
(d) Employment opportunities;
(e) Neighborhood environment; and
(f) Transportation.

(2) The Oregon Health Authority shall collaborate with coordinated care organizations to develop specific metrics for a coordinated care organization’s annual investments in the social determinants of health of its members. The metrics must be consistent with the requirements for medical loss ratios contained in the terms and conditions of the demonstration project approved by the Centers for Medicare and Medicaid Services.

SECTION 5. The Oregon Health Authority shall establish a structure for collaboration between coordinated care organizations and community mental health programs in each geographical region of this state in the delivery of behavioral health services to ensure that all Oregonians’ behavioral health needs are aligned, coordinated and directed by coordinated care organizations. Each collaboration must have a model of governance and finance that builds on existing structures and is led by the coordinated care organizations.

SECTION 6. Section 19, chapter 418, Oregon Laws 2011, as amended by section 6, chapter 359, Oregon Laws 2015, is repealed.

SECTION 7. ORS 414.625 is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Each coordinated care organization complies with the safeguards for members described in
ORS 413.635.

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

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

(k) Members have a choice of providers within the coordinated care organization’s network and
that providers participating in a coordinated care organization:
(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

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

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

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

(E) Include providers of specialty care.

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

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

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

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

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

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

(A) A representative of a dental care organization selected by the coordinated care organization;

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

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

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

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

(D) At least two members from the community at large, who have no financial interest in the coordinated care organization, to ensure that the organization’s decision-making is consistent with the values of the members and the community; and

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

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

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

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

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

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

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

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

SECTION 8. ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization’s demonstrated experience and capacity for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

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

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

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

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

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

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

(E) Include providers of specialty care.

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

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

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

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

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

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

(A) A representative of a dental care organization selected by the coordinated care organization;

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

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

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

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

(D) At least two members from the community at large, who have no financial interest in the coordinated care organization, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

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

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

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

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

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

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

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

SECTION 9. Section 3 of this 2018 Act is repealed on January 2, 2024.