

House Bill 3106

Sponsored by Representative RESCHKE

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 organization that manages its own dental program to have licensed dentist on site at least one day each week.

A BILL FOR AN ACT

1 Relating to dental care provided by coordinated care organizations; amending ORS 414.625.

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

3 **SECTION 1.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended
4 to read:

5
6 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
7 quirements for a coordinated care organization and shall integrate the criteria and requirements
8 into each contract with a coordinated care organization. Coordinated care organizations may be
9 local, community-based organizations or statewide organizations with community-based participation
10 in governance or any combination of the two. Coordinated care organizations may contract with
11 counties or with other public or private entities to provide services to members. The authority may
12 not contract with only one statewide organization. A coordinated care organization may be a single
13 corporate structure or a network of providers organized through contractual relationships. The cri-
14 teria and requirements adopted by the authority under this section must include, but are not limited
15 to, a requirement that the coordinated care organization:

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

18 (b) Meet the following minimum financial requirements:

19 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
20 nated care organization's total actual or projected liabilities above \$250,000.

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

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

29 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-
30 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care
31 organization's total expenditures for physical and mental health care provided to members, except

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 for expenditures on prescription drugs, vision care and dental care.

2 (d) Develop and implement alternative payment methodologies that are based on health care
3 quality and improved health outcomes.

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

6 (f) Engage community members and health care providers in improving the health of the com-
7 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
8 exist among the coordinated care organization's members and in the coordinated care organization's
9 community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (E) Include providers of specialty care.

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

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

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

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

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

19 (o) Each coordinated care organization has a governing body that complies with section 2,
20 chapter 49, Oregon Laws 2018, and that includes:

21 (A) At least one member representing persons that share in the financial risk of the organiza-
22 tion;

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

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

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

26 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
27 678.375, whose area of practice is primary care; and

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

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

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

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

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

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

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

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

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

43 (5)(a) On or before July 1, 2014, each coordinated care organization must have a formal con-
44 tractual relationship with any dental care organization that serves members of the coordinated care
45 organization in the area where they reside.

1 **(b) A coordinated care organization that manages its own dental program must have a**
 2 **licensed dentist on site at least one day each week. The authority may, by rule, require the**
 3 **coordinated care organization to have the dentist on site more frequently than one day each**
 4 **week based on the number of members enrolled in the coordinated care organization.**

5 **SECTION 2.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and sec-
 6 tion 4, chapter 49, Oregon Laws 2018, is amended to read:

7 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
 8 quirements for a coordinated care organization and shall integrate the criteria and requirements
 9 into each contract with a coordinated care organization. Coordinated care organizations may be
 10 local, community-based organizations or statewide organizations with community-based participation
 11 in governance or any combination of the two. Coordinated care organizations may contract with
 12 counties or with other public or private entities to provide services to members. The authority may
 13 not contract with only one statewide organization. A coordinated care organization may be a single
 14 corporate structure or a network of providers organized through contractual relationships. The cri-
 15 teria and requirements adopted by the authority under this section must include, but are not limited
 16 to, a requirement that the coordinated care organization:

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

19 (b) Meet the following minimum financial requirements:

20 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-
 21 nated care organization’s total actual or projected liabilities above \$250,000.

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

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

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

34 (d) Develop and implement alternative payment methodologies that are based on health care
 35 quality and improved health outcomes.

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

38 (f) Engage community members and health care providers in improving the health of the com-
 39 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
 40 exist among the coordinated care organization’s members and in the coordinated care organization’s
 41 community.

42 (2) In addition to the criteria and requirements specified in subsection (1) of this section, the
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 44 authority so that:

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1 and services designed to provide choice, independence and dignity.

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3 for comprehensive care management and service delivery.

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

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

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

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

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

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

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

24 (j) Each coordinated care organization prioritizes working with members who have high health
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27 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
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34 integrated system about a patient's treatment plan and health history.

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32 organization in the area where they reside.

33 **(b) A coordinated care organization that manages its own dental program must have a**
34 **licensed dentist on site at least one day each week. The authority may, by rule, require the**
35 **coordinated care organization to have the dentist on site more frequently than one day each**
36 **week based on the number of members enrolled in the coordinated care organization.**

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