House Bill 3279

Sponsored by COMMITTEE ON HEALTH CARE (at the request of Multnomah County Health Department)

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 Oregon Health Authority to establish uniform payment amounts applicable to medical assistance payments to providers of substance use disorder services and providers of mental health treatment.

A BILL FOR AN ACT

Relating to mental health; creating new provisions; and amending ORS 413.201, 414.025, 414.153, 414.625, 414.651, 414.704 and 430.637.

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

SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS chapter 414.

SECTION 2. (1) A provider of substance use disorder services paid with medical assistance funds, in whole or in part, shall be paid for each service an amount established by the Oregon Health Authority. The payment amount for providers of substance abuse disorder treatment must be the same as the payment amount for providers of mental health treatment.

(2) This section does not prohibit the Oregon Health Authority or a coordinated care organization from using alternative payment methodologies to reimburse providers of substance abuse disorder treatment as long as the methodologies apply equally to providers of mental health treatment.

SECTION 3. The Oregon Health Authority and coordinated care organizations may not reduce the amount paid to providers of mental health treatment for the purpose of complying with section 2 of this 2019 Act.

SECTION 4. ORS 414.025 is amended to read:

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

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

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

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

(3) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

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.

(b) A licensed psychologist;

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

(d) A licensed clinical social worker;

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

(f) A certified clinical social work associate;

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

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

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

(5) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

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

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

(a) Has expertise or experience in public health;

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

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

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

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

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

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

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

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

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

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

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

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

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

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

(b) A "family support specialist" may be a peer wellness specialist or a peer support specialist.

(11) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

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

(13) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

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

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) [*Chemical dependency*] **Substance use disorder** services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

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

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

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

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

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

(E) Personal health navigators; or

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

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

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

(18) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

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

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(20) "Peer support specialist" means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or [*addiction*] **substance use disorder** treatment:

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

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from [*an addiction*] **a substance use** disorder.

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

(22) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

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

and

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

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

(24) "Prepaid managed care health services organization" means a managed dental care, mental health or [*chemical dependency*] **substance use disorder** organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(25) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(26) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(27)(a) "Youth support specialist" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

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

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

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

(b) A "youth support specialist" may be a peer wellness specialist or a peer support specialist.

SECTION 5. ORS 413.201 is amended to read:

413.201. (1) The Oregon Health Authority is responsible for statewide outreach and marketing of the Health Care for All Oregon Children program established in ORS 414.231 and administered by the authority with the goal of enrolling in the program all eligible children residing in this state. The authority, in collaboration with the work group described in subsection (3) of this section, shall evaluate and implement the outreach and marketing strategies designed to most effectively encourage the enrollment of children in the program.

(2) To maximize the enrollment and retention of eligible children in the Health Care for All Oregon Children program, the authority shall develop and administer a grant program to provide funding to organizations and community based groups to deliver culturally specific and targeted outreach and direct application assistance to:

(a) Members of racial, ethnic and language minority communities;

(b) Children living in geographic isolation; and

(c) Children and family members with additional barriers to accessing health care, such as cognitive, mental health or sensory disorders, physical disabilities or [*chemical dependency*] **substance use disorders**, and children experiencing homelessness.

(3) The authority shall convene a work group, consisting of individuals with experience in conducting outreach to the individuals described in subsection (2)(a) to (c) of this section, to advise and assist the authority in carrying out its duties under this section.

SECTION 6. ORS 414.153 is amended to read:

414.153. In order to make advantageous use of the system of public health care and services

available through local health departments and other publicly supported programs and to ensure access to public health care and services through contract under ORS chapter 414, the state shall:

(1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between coordinated care organizations and publicly funded providers for authorization of payment for point of contact services in the following categories:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

(2) Allow members of coordinated care organizations to receive from fee-for-service providers:

(a) Family planning services;

(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and

(c) Maternity case management if the Oregon Health Authority determines that a coordinated care organization cannot adequately provide the services;

(3) Encourage and approve agreements between coordinated care organizations and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;

(e) Health care and services for children provided through schools and Head Start programs; and

(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and

(4) Recognize the responsibility of counties under ORS 430.620 to operate community mental health programs by requiring a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority. The written agreements:

(a) May not prevent coordinated care organizations from contracting with other public or private providers for mental health or [*chemical dependency*] **substance use disorder** services;

(b) Must include agreed upon outcomes; and

(c) Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:

(A) Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

(B) Care coordination of residential services and supports for adults and children;

(C) Management of the mental health crisis system;

(D) Management of community-based specialized services, including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children; and

(E) Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

SECTION 7. ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, 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) Meet the following minimum financial requirements:

(A) 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) 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) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, 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) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) 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*] **substance use disorders** 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 that complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

(D) 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*] **substance use disorder** treatment provider;

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

(F) 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, and section 4, chapter 49, Oregon Laws 2018, 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) Meet the following minimum financial requirements:

(A) 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) 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) Operate within a fixed global budget and spend 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) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) 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*] **substance use disorders** 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 that complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

(D) 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*] **substance use disorder** treatment provider;

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

(F) 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 9. ORS 414.651 is amended to read:

414.651. (1)(a) The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, [*chemical dependency and*] **substance use disorder services,** mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

(b) The authority shall execute contracts with coordinated care organizations that meet the criteria adopted by the authority under ORS 414.625. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(c) The authority shall establish financial reporting requirements for coordinated care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each coordinated care organization and that:

(A) Enables the authority to verify that the coordinated care organization's reserves and other financial resources are adequate to ensure against the risk of insolvency; and

(B) Includes information on the three highest executive salary and benefit packages of each coordinated care organization.

(d) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

(e) The authority shall require compliance with the provisions of paragraphs (c) and (d) of this subsection as a condition of entering into a contract with a coordinated care organization. A coordinated care organization, contractor or provider that fails to comply with paragraph (c) or (d) of this subsection may be subject to sanctions, including but not limited to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.

(f)(A) The authority shall adopt rules and procedures to ensure that if a rural health clinic provides a health service to a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care organization, the rural health clinic receives total aggregate payments from the member's coordinated care organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule

and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services provided pursuant to **this section and** ORS 414.631[*, 414.651*] and 414.688 to 414.745 may not exceed the total dollars appropriated for health services under ORS 414.631, 414.651 and 414.688 to 414.745.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with **this section and** ORS 414.631, [*414.651,*] 414.654 and 414.688 to 414.745 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under **this section and** ORS 414.631[*, 414.651*] and 414.688 to 414.745 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

(7) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

(8) Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to members.

(9) A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member.

SECTION 10. ORS 414.704 is amended to read:

414.704. The Health Evidence Review Commission shall consult with an advisory committee in determining priorities for mental health care and [*chemical dependency*] **substance use disorder treatment**. The advisory committee shall include mental health and [*chemical dependency*] **substance use disorder treatment** professionals who provide inpatient and outpatient mental health and [*chemical dependency care*] **substance use disorder treatment**.

SECTION 11. ORS 430.637 is amended to read:

430.637. (1) As used in this section:

(a) "Assessment" means an on-site quality assessment of an organizational provider that is conducted:

(A) If the provider has not been accredited by a national organization meeting the quality standards of the Oregon Health Authority;

(B) By the Oregon Health Authority, another state agency or a contractor on behalf of the authority or another state agency; and

(C) For the purpose of issuing a certificate of approval.

(b) "Organizational provider" means an organization that provides mental health treatment or [*chemical dependency*] **substance use disorder** treatment and is not a coordinated care organization.

(2) The Oregon Health Authority shall convene a committee, in accordance with ORS 183.333, to advise the authority with respect to the adoption, by rule, of criteria for an assessment. The advisory committee shall advise the authority during the development of the criteria. The advisory committee shall be reconvened as needed to advise the authority with respect to updating the criteria to conform to changes in national accreditation standards or federal requirements for health plans and to advise the authority on opportunities to improve the assessment process. The advisory committee shall include, but is not limited to:

(a) A representative of each coordinated care organization certified by the authority;

(b) Representatives of organizational providers;

(c) Representatives of insurers and health care service contractors that have been accredited by the National Committee for Quality Assurance; and

(d) Representatives of insurers that offer Medicare Advantage Plans that have been accredited by the National Committee for Quality Assurance.

(3) The advisory committee described in subsection (2) of this section shall recommend:

(a) Objective criteria for a shared assessment tool that complies with national accreditation standards and federal requirements for health plans;

(b) Procedures for conducting an assessment;

(c) Procedures to eliminate redundant reporting requirements for organizational providers; and

(d) A process for addressing concerns that arise between assessments regarding compliance with quality standards.

(4) If another state agency, or a contractor on behalf of the state agency, conducts an assessment that meets the criteria adopted by the authority under subsection (2) of this section, the authority may rely on the assessment as evidence that the organizational provider meets the assessment requirement for receiving a certificate of approval.

(5) The authority shall provide a report of an assessment to the organizational provider that was assessed and, upon request, to a coordinated care organization, insurer or health care service contractor.

(6) If an organizational provider has not been accredited by a national organization that is acceptable to a coordinated care organization, the coordinated care organization shall rely on the assessment conducted in accordance with the criteria adopted under subsection (2) of this section as evidence that the organizational provider meets the assessment requirement.

(7) This section does not:

(a) Prevent a coordinated care organization from requiring its own on-site quality assessment if the authority, another state agency or a contractor on behalf of the authority or another state agency has not conducted an assessment in the preceding 36-month period; or

(b) Require a coordinated care organization to contract with an organizational provider.

(8)(a) The authority shall adopt by rule standards for determining whether information requested by a coordinated care organization from an organizational provider is redundant with respect to the reporting requirements for an assessment or if the information is outside of the scope of the assessment criteria.

(b) A coordinated care organization may request additional information from an organizational provider, in addition to the report of the assessment, if the request:

(A) Is not redundant and is within the scope of the assessment according to standards adopted by the authority as described in this subsection; and

(B) Is necessary to resolve questions about whether an organizational provider meets the coordinated care organization's policies and procedures for credentialing.

(c) The authority shall implement a process for resolving a complaint by an organizational provider that a reporting requirement imposed by a coordinated care organization is redundant or outside of the scope of the assessment criteria.

(9)(a) The authority shall establish and maintain a database containing the documents required by coordinated care organizations for the purpose of credentialing an organizational provider.

(b) With the advice of the committee described in subsection (2) of this section, the authority shall adopt by rule the content and operational function of the database including, at a minimum:

(A) The types of organizational providers for which information is stored in the database;

(B) The types and contents of documents that are stored in the database;

(C) The frequency by which the documents the authority shall obtain updated documents;

(D) The means by which the authority will obtain the documents; and

(E) The means by which coordinated care organizations can access the documents in the database.

(c) The authority shall provide training to coordinated care organization staff who are responsible for processing credentialing requests on the use of the database.

SECTION 12. Section 2 of this 2019 Act applies to substance use disorder services provided on or after the effective date of this 2019 Act.