

SB 134-1
(LC 1400)
3/1/19 (SCT/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE (at the request of Multnomah County)

**PROPOSED AMENDMENTS TO
SENATE BILL 134**

1 On page 1 of the printed bill, line 2, after “care;” delete the rest of the
2 line and insert “creating new provisions; amending ORS 414.625 and 414.635;
3 and prescribing an effective date.”.

4 Delete lines 4 through 29 and delete page 2 and insert:

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

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

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

1 “(b) Meet the following minimum financial requirements:

2 “(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50
3 percent of the coordinated care organization’s total actual or projected li-
4 abilities above \$250,000.

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

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

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

20 “(d) Develop and implement alternative payment methodologies that are
21 based on health care quality and improved health outcomes.

22 “(e) Coordinate the delivery of physical health care, mental health and
23 chemical dependency services, oral health care and covered long-term care
24 services.

25 “(f) Engage community members and health care providers in improving
26 the health of the community and addressing regional, cultural, socioeconomic
27 and racial disparities in health care that exist among the coordinated care
28 organization’s members and in the coordinated care organization’s commu-
29 nity.

30 “(2) In addition to the criteria and requirements specified in subsection

1 (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

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

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

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

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

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

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

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

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

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

1 “(j) Each coordinated care organization prioritizes working with members
2 who have high health care needs, multiple chronic conditions, mental illness
3 or chemical dependency and involves those members in accessing and man-
4 aging appropriate preventive, health, remedial and supportive care and ser-
5 vices, including the services described in ORS 414.766, to reduce the use of
6 avoidable emergency room visits and hospital admissions.

7 “(k) Members have a choice of providers within the coordinated care
8 organization’s network and that providers participating in a coordinated care
9 organization:

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

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

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

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

19 “(E) Include providers of specialty care.

20 “(F) Are selected by coordinated care organizations using universal ap-
21 plication and credentialing procedures and objective quality information and
22 are removed if the providers fail to meet objective quality standards.

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

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

29 “(m) Each coordinated care organization uses best practices in the man-
30 agement of finances, contracts, claims processing, payment functions and

1 provider networks.

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

4 “(o) Each coordinated care organization has a governing body that com-
5 plies with section 2, chapter 49, Oregon Laws 2018, and that includes:

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

8 “(B) A representative of a dental care organization selected by the coor-
9 dinated care organization;

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

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

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

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

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

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

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

23 **“(q) Each coordinated care organization publishes on a website**
24 **maintained by or on behalf of the coordinated care organization, in a**
25 **manner determined by the authority, a document designed to educate**
26 **members about best practices, care quality expectations, screening**
27 **practices, treatment options and other support resources available for**
28 **members who have mental illnesses or substance use disorders.**

29 “(3) The authority shall consider the participation of area agencies and
30 other nonprofit agencies in the configuration of coordinated care organiza-

1 tions.

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

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

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

8 “(c) Allow more than one coordinated care organization to serve the ge-
9 ographic area if necessary to optimize access and choice under this sub-
10 section.

11 “(5) On or before July 1, 2014, each coordinated care organization must
12 have a formal contractual relationship with any dental care organization
13 that serves members of the coordinated care organization in the area where
14 they reside.

15 **“SECTION 2.** ORS 414.625, as amended by section 14, chapter 489, Oregon
16 Laws 2017, and section 4, chapter 49, Oregon Laws 2018, is amended to read:

17 “414.625. (1) The Oregon Health Authority shall adopt by rule the quali-
18 fication criteria and requirements for a coordinated care organization and
19 shall integrate the criteria and requirements into each contract with a co-
20 ordinated care organization. Coordinated care organizations may be local,
21 community-based organizations or statewide organizations with community-
22 based participation in governance or any combination of the two. Coordi-
23 nated care organizations may contract with counties or with other public or
24 private entities to provide services to members. The authority may not con-
25 tract with only one statewide organization. A coordinated care organization
26 may be a single corporate structure or a network of providers organized
27 through contractual relationships. The criteria and requirements adopted by
28 the authority under this section must include, but are not limited to, a re-
29 quirement that the coordinated care organization:

30 “(a) Have demonstrated experience and a capacity for managing financial

1 risk and establishing financial reserves.

2 “(b) Meet the following minimum financial requirements:

3 “(A) Maintain restricted reserves of \$250,000 plus an amount equal to 50
4 percent of the coordinated care organization’s total actual or projected li-
5 abilities above \$250,000.

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

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

16 “(c) Operate within a fixed global budget and spend on primary care, as
17 defined by the authority by rule, at least 12 percent of the coordinated care
18 organization’s total expenditures for physical and mental health care pro-
19 vided to members, except for expenditures on prescription drugs, vision care
20 and dental care.

21 “(d) Develop and implement alternative payment methodologies that are
22 based on health care quality and improved health outcomes.

23 “(e) Coordinate the delivery of physical health care, mental health and
24 chemical dependency services, oral health care and covered long-term care
25 services.

26 “(f) Engage community members and health care providers in improving
27 the health of the community and addressing regional, cultural, socioeconomic
28 and racial disparities in health care that exist among the coordinated care
29 organization’s members and in the coordinated care organization’s commu-
30 nity.

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

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

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

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

14 “(d) Members receive comprehensive transitional care, including appro-
15 priate follow-up, when entering and leaving an acute care facility or a long
16 term care setting.

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

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22 members reside as possible and are, if available, offered in nontraditional
23 settings that are accessible to families, diverse communities and underserved
24 populations.

25 “(g) Each coordinated care organization uses health information technol-
26 ogy to link services and care providers across the continuum of care to the
27 greatest extent practicable and if financially viable.

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

30 “(i) Each coordinated care organization convenes a community advisory

1 council that meets the criteria specified in ORS 414.627.

2 “(j) Each coordinated care organization prioritizes working with members
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4 or chemical dependency and involves those members in accessing and man-
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7 avoidable emergency room visits and hospital admissions.

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12 to reduce waste and improve the health and well-being of members.

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

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

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

20 “(E) Include providers of specialty care.

21 “(F) Are selected by coordinated care organizations using universal ap-
22 plication and credentialing procedures and objective quality information and
23 are removed if the providers fail to meet objective quality standards.

24 “(G) Work together to develop best practices for culturally appropriate
25 care and service delivery to reduce waste, reduce health disparities and im-
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27 “(L) Each coordinated care organization reports on outcome and quality
28 measures adopted under ORS 414.638 and participates in the health care data
29 reporting system established in ORS 442.464 and 442.466.

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1 agement of finances, contracts, claims processing, payment functions and
2 provider networks.

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

5 “(o) Each coordinated care organization has a governing body that com-
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8 risk of the organization;

9 “(B) A representative of a dental care organization selected by the coor-
10 dinated care organization;

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

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

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

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

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

24 **“(q) Each coordinated care organization publishes on a website**
25 **maintained by or on behalf of the coordinated care organization, in a**
26 **manner determined by the authority, a document designed to educate**
27 **members about best practices, care quality expectations, screening**
28 **practices, treatment options and other support resources available for**
29 **members who have mental illnesses or substance use disorders.**

30 “(3) The authority shall consider the participation of area agencies and

1 other nonprofit agencies in the configuration of coordinated care organiza-
2 tions.

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

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

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

9 “(c) Allow more than one coordinated care organization to serve the ge-
10 ographic area if necessary to optimize access and choice under this sub-
11 section.

12 “(5) On or before July 1, 2014, each coordinated care organization must
13 have a formal contractual relationship with any dental care organization
14 that serves members of the coordinated care organization in the area where
15 they reside.

16 **“SECTION 3.** ORS 414.635 is amended to read:

17 “414.635. (1) The Oregon Health Authority shall adopt by rule safeguards
18 for members enrolled in coordinated care organizations that protect against
19 underutilization of services and inappropriate denials of services. In addition
20 to any other consumer rights and responsibilities established by law, each
21 member:

22 “(a) Must be encouraged to be an active partner in directing the member’s
23 health care and services and not a passive recipient of care.

24 “(b) Must be educated about the coordinated care approach being used in
25 the community, **including the approach to addressing behavioral health**
26 **care, and provided with any assistance needed regarding** how to navi-
27 gate the coordinated health care system.

28 “(c) Must have access to advocates, including qualified peer wellness
29 specialists, peer support specialists, personal health navigators, and qualified
30 community health workers who are part of the member’s care team to pro-

1 vide assistance that is culturally and linguistically appropriate to the
2 member's need to access appropriate services and participate in processes
3 affecting the member's care and services.

4 “(d) Shall be encouraged within all aspects of the integrated and coordi-
5 nated health care delivery system to use wellness and prevention resources
6 and to make healthy lifestyle choices.

7 “(e) Shall be encouraged to work with the member's care team, including
8 providers and community resources appropriate to the member's needs as a
9 whole person.

10 “(2) The authority shall establish and maintain an enrollment process for
11 individuals who are dually eligible for Medicare and Medicaid that promotes
12 continuity of care and that allows the member to disenroll from a coordi-
13 nated care organization that fails to promptly provide adequate services and:

14 “(a) To enroll in another coordinated care organization of the member's
15 choice; or

16 “(b) If another organization is not available, to receive Medicare-covered
17 services on a fee-for-service basis.

18 “(3) Members and their providers and coordinated care organizations have
19 the right to appeal decisions about care and services through the authority
20 in an expedited manner and in accordance with the contested case procedures
21 in ORS chapter 183.

22 “(4) A health care entity may not unreasonably refuse to contract with
23 an organization seeking to form a coordinated care organization if the par-
24 ticipation of the entity is necessary for the organization to qualify as a co-
25 ordinated care organization.

26 “(5) A health care entity may refuse to contract with a coordinated care
27 organization if the reimbursement established for a service provided by the
28 entity under the contract is below the reasonable cost to the entity for pro-
29 viding the service.

30 “(6) A health care entity that unreasonably refuses to contract with a

1 coordinated care organization may not receive fee-for-service reimbursement
2 from the authority for services that are available through a coordinated care
3 organization either directly or by contract.

4 “(7)(a) The authority shall adopt by rule a process for resolving disputes
5 involving:

6 “(A) A health care entity’s refusal to contract with a coordinated care
7 organization under subsections (4) and (5) of this section.

8 “(B) The termination, extension or renewal of a health care entity’s con-
9 tract with a coordinated care organization.

10 “(b) The processes adopted under this subsection must include the use of
11 an independent third party arbitrator.

12 “(8) A coordinated care organization may not unreasonably refuse to
13 contract with a licensed health care provider.

14 “(9) The authority shall:

15 “(a) Monitor and enforce consumer rights and protections within the
16 Oregon Integrated and Coordinated Health Care Delivery System and ensure
17 a consistent response to complaints of violations of consumer rights or pro-
18 tections.

19 “(b) Monitor and report on the statewide health care expenditures and
20 recommend actions appropriate and necessary to contain the growth in
21 health care costs incurred by all sectors of the system.

22 **“SECTION 4. (1) The amendments to ORS 414.625 and 414.635 by
23 sections 1 to 3 of this 2019 Act become operative on January 1, 2020.**

24 **“(2) The Oregon Health Authority may take any action before the
25 operative date specified in subsection (1) of this section that is neces-
26 sary to enable the authority to exercise, on and after the operative
27 date specified in subsection (1) of this section, all of the duties, func-
28 tions and powers conferred on the authority by the amendments to
29 ORS 414.625 and 414.635 by sections 1 to 3 of this 2019 Act.**

30 **“SECTION 5. This 2019 Act takes effect on the 91st day after the**

1 **date on which the 2019 regular session of the Eightieth Legislative**
2 **Assembly adjourns sine die.”**

3 _____