SB 1551-1
(LC 92)
2/10/20 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE

PROPOSED AMENDMENTS TO
SENATE BILL 1551

On page 1 of the printed bill, line 2, after "ORS" insert "411.408, 414.572," and after "414.591," insert "414.605,".

On page 2, after line 22, insert:

"SECTION 5. ORS 414.572 is amended to read:

"414.572. (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 capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

"(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 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 coor-

dinated 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 414.605.

"(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

"(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 442.372 and 442.373.

"(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 ORS 414.584 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 licensed under ORS 678.375, whose area of practice is primary care; and

"(ii) A mental health or chemical dependency 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 two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

"(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.

"(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental

illnesses or substance use disorders.

"(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

"(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

"(B) Participate in the community health assessment and the development of the health improvement plan;

"(C) Communicate regularly with the Tribal Advisory Council; and

"(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

"(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 6. ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364, Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon Laws 2019, is amended to read:

"414.572. (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 capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

"(C) Expend a portion of the annual net income or reserves of the coor-

dinated 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 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 414.605.

"(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

"(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 442.372 and 442.373.

"(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 ORS 414.584 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 coor-

dinated 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 licensed under ORS 678.375, whose area of practice is primary care; and

"(ii) A mental health or chemical dependency 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 two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

"(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.

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

"(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

"(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

"(B) Participate in the community health assessment and the development of the health improvement plan;

"(C) Communicate regularly with the Tribal Advisory Council; and

"(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

"(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.".

In line 23, delete "5" and insert "7".

On page 4, after line 13, insert:

"SECTION 8. ORS 414.605 is amended to read:

"414.605. **(1) As used in this section:**

"(a) 'Agent' means a person acting or negotiating on behalf of another person.

"(b) 'Health care entity' means:

"(A) A health care provider or group of health care providers;

"(B) An organization that provides health care; or

"(C) A health care provider, a group of health care providers or an organization that provides health care, represented by an agent.

"[*(1)*] **(2)** The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

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

"(b) Must be educated about the coordinated care approach being used in the community, including the approach to addressing behavioral health care, and provided with any assistance needed regarding how to navigate the coordinated health care system.

"(c) Must have access to advocates, including qualified peer wellness specialists, peer support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

"(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

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

"[*(2)*] **(3)** The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that

promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

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

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

"[*(3)*] **(4)** Members and their providers and coordinated care organizations have the right to appeal decisions about care and services through the authority in an expedited manner and in accordance with the contested case procedures in ORS chapter 183.

"[*(4)*] **(5)(a)** A health care entity **or a agent of a health care entity** may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to**:**

"(A) Qualify as a coordinated care organization**; or**

"(B) Establish an adequate provider network under ORS 414.609 in a geographic service area for which the organization has received preliminary approval from the authority to become a coordinated care organization.

"**(b) A health care entity or an agent of a health care entity may not unreasonably refuse to contract with a coordinated care organization if the participation of the health care entity is necessary for the coordinated care organization to maintain network adequacy under ORS 414.609 for its existing geographic service area and members.**

"(c) Any refusal to contract must be in writing, state the reasons for the refusal and be sent to the organization seeking to form a coordinated care organization or the coordinated care organization, with a copy sent to the authority, no later than 10 days after the offer to contract is communicated to the health care entity.

"(d) A refusal to contract under this subsection includes a refusal to renew or extend a contract.

"(e) An unreasonable refusal to contract under this subsection includes, but is not limited to, a refusal based on the preference of the health care entity to contract with two or fewer coordinated care organizations within a geographic service area.

"[*(5)*] **(6)** A health care entity **or an agent of a health care entity** may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

"[*(6)*] **(7) If** a health care entity [*that*] **or the health care entity's agent** unreasonably refuses to contract with a coordinated care organization**, the health care entity** may not [*receive fee-for-service reimbursement from*] **be reimbursed by** the authority for services that are available through [*a*] **the** coordinated care organization either directly or by contract.

"[*(7)(a)*] **(8)(a)** The authority shall adopt by rule a process for resolving**, within 30 days,** disputes involving:

"(A) A health care entity's **or the health care entity's agent's** refusal to contract with **an organization seeking to form a coordinated care organization or** a coordinated care organization under subsections [*(4) and (5)*] **(5) and (6)** of this section.

"(B) The termination, extension or renewal of a health care entity's contract with a coordinated care organization.

"**(C) A coordinated care organization's refusal to contract with a licensed health care provider under subsection (9) of this section.**

"(b) The [*processes*] **process** adopted under this subsection must include the use of an independent third party arbitrator **and the opportunity for either party to a dispute to initiate the process at any time**.

"**(c) If a party to a dispute refuses to fully comply with a decision of the independent third party arbitrator, the authority shall take ap-**

propriate steps including, but not limited to:

"(A) Modifying or terminating the authority's contract with a coordinated care organization that refuses to comply;

"(B) Withholding reimbursement to a health care entity that refuses to comply; or

"(C) Prohibiting any coordinated care organization from making payments for the cost of services provided to members of the coordinated care organization, in amounts exceeding the fee-for-service rates established by the authority under ORS 414.065, to a health care entity that refuses to comply.

"[*(8)*] **(9)** A coordinated care organization may not unreasonably refuse to contract with a licensed health care provider.

"[*(9)*] **(10)** The authority shall:

"(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

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

In line 14, delete "6" and insert "9".

On page 5, line 5, delete "7" and insert "10".

After line 27, insert:

"SECTION 11. ORS 411.408 is amended to read:

"411.408. In addition to the requirements in ORS 414.605 [*(3)*] **(4)** and 414.712 (5), if the Oregon Health Authority or the Department of Human Services denies a claim for medical assistance or fails to act with reasonable promptness on a claim for medical assistance, the person making the claim may request a contested case hearing. The hearing shall be held at a time and place and shall be conducted in accordance with rules adopted by the

authority or the department, as appropriate.".

In line 28, delete "8" and insert "12".

In line 29, delete "9" and insert "13".