House Bill 4153

Sponsored by Representative FREEMAN, Senator BATES (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Establishes criteria for coordinated care organizations. Requires that community advisory council be convened for each organization and specifies duties of council. Prescribes actuarially sound global budgeting process. Creates metrics and scoring committee to establish outcomes measures.

Establishes Oregon Defensive Medicine Task Force to make recommendation for legislative concept to address practice of defensive medicine.

Makes coordinated care organizations public bodies for purposes of Oregon Tort Claims Act.

Makes technical and conforming amendments.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care delivery; creating new provisions; amending ORS 411.095, 414.025, 414.033, 414.625, 414.632, 414.635, 414.638, 414.740 and 416.540 and sections 14, 62, 63 and 64, chapter 602, Oregon Laws 2011; and declaring an emergency.

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

COORDINATED CARE ORGANIZATION REQUIREMENTS

SECTION 1. (1) A prepaid managed care health services organization that contracts with the Oregon Health Authority on the effective date of this 2012 Act and applies to become a coordinated care organization is not subject to the criteria adopted under ORS 414.625 (1) except the requirements of ORS 414.625 (1)(o)(B) and (C), but must demonstrate:

(a) Five years or more of experience in managing acute physical health care;

(b) That it has the capacity to:

(A) Coordinate and deliver physical, mental and dental health services, including services that do not have assigned billing codes; and

(B) Manage financial risk; and

(c) That it has the expertise to provide physical, mental and dental health services to individuals who are dually eligible for Medicare and Medicaid.

(2) The authority shall approve coordinated care organizations meeting the criteria of this section no later than July 1, 2012.

SECTION 2. (1) A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:

(a) Include representatives of the community and of each county served by the organization, but consumer representatives must constitute a majority of the membership;

(b) Meet no less frequently than once every three months; and

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.

(c) Have its membership selected by a committee composed of equal numbers of county representatives and members of the governing body of the organization.

(2) The duties of the council shall include, but are not limited to:

(a) Identifying and advocating for preventive care practices to be utilized by the organization;

(b) Developing a community wellness program; and

(c) Annually publishing a report on the health of the organization that includes a review of the work of the organization and recommendations to the governing body of the organization for changes or improvements.

SECTION 3. (1) The Oregon Health Authority shall pay coordinated care organizations using an actuarially sound global budgeting process. In a global budgeting process:

(a) All federal funds received under Titles XIX and XXI of the Social Security Act for the care of the members of the organization must be included in the global budget of the organization;

(b) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

(c) The payment must be based upon an community needs assessment conducted by the organization and reviewed annually, and upon the organization's health care costs as verified by the authority under subsection (2) of this section; and

(d) The authority must adjust the global budget to reflect changes to services resulting from an arbitration described in ORS 414.635 (7). If the payment cannot be adjusted, the authority must adjust the scope of the required services to account for any increased costs.

(2)(a) A coordinated care organization shall estimate health care costs prescribed by the authority, using actuarially sound methods.

(b) The authority must verify any health care costs reported by an organization under this subsection that are used by the authority to establish global budgets.

(3) The authority must facilitate the needs assessment conducted by the organization by assisting in the collection of data or other appropriate assistance.

SECTION 4. (1) The Oregon Health Authority shall assign to each coordinated care organization one employee of the authority, called an innovator agent, to act as the single point of contact between the coordinated care organization and the authority. The innovator agent must be available to the organization on a day-to-day basis to facilitate the exchange of information between the organization and the authority.

(2) Innovator agents must observe the meetings of the community advisory councils and report on the meetings to the authority.

(3) Not less than once every calendar quarter all of the innovator agents must meet in person to discuss the ideas, projects and creative innovations planned or undertaken by their assigned coordinated care organizations.

SECTION 5. Section 6 of this 2012 Act is added to and made a part of ORS chapter 414.

SECTION 6. (1) A coordinated care organization is a local public body for purposes of ORS 30.260 to 30.300.

(2) A health care provider that contracts with a coordinated care organization to provide health services to members of the organization that are paid for by the Oregon Health Authority is an agent of the coordinated care organization under ORS 30.260 to 30.300 for the purpose of tort claims arising out of those health services.

(3) A coordinated care organization shall impose an assessment on each health care provider that contracts with the organization to provide health services to members of the organization. The assessments collected shall be used only for the purpose of paying the costs incurred by the organization to defend, save harmless and indemnify the organization and the contracting health care providers against any tort claim, whether groundless or otherwise, arising out of an alleged act or omission occurring in the provision of health services through the organization.

(4) The state is not liable to any person for an act or omission occurring in the provision of health services through a coordinated care organization.

SECTION 7. Section 6 of this 2012 Act applies only to causes of action that arise on or after January 1, 2013.

SECTION 8. (1) The Oregon Defensive Medicine Task Force is created consisting of six members appointed by the Governor and confirmed by the Senate in accordance with section 4, Article III of the Oregon Constitution. The membership must consist of equal numbers of representatives of plaintiffs' attorneys and representatives of health care providers.

(2) The task force shall study the practice of defensive medicine. A health care provider practices defensive medicine when the provider orders an unnecessary test or procedure based on the provider's concern about malpractice liability.

(3) The task force shall develop a legislative concept to address the issue of defensive medicine. The Governor shall submit the legislative concept to Legislative Counsel in accordance with rules adopted by the Senate and the House of Representatives.

(4) A majority of the voting members of the task force constitutes a quorum for the transaction of business.

(5) Official action by the task force requires the approval of a majority of the voting members of the task force.

(6) The task force shall elect one of its members to serve as chairperson.

(7) If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective.

(8) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the task force.

(9) The task force may adopt rules necessary for the operation of the task force.

(10) The Oregon Health Authority shall provide staff support to the task force.

(11) Members of the task force are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the Oregon Health Authority for purposes of the task force.

(12) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of its duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the task force consider necessary to perform their duties.

SECTION 9. ORS 411.095 is amended to read:

411.095. (1) Except as provided in subsection (2) of this section, when the Department of Human Services changes a benefit standard that results in the reduction, suspension or closure of a grant of general assistance or a grant of public assistance, the department shall mail a notice of intended

action to each recipient affected by the change at least 30 days before the effective date of the action.

(2) If the department has fewer than 60 days before the effective date to implement a proposed change described in subsection (1) of this section, the department shall mail a notice of intended action to each recipient affected by the change as soon as practicable but at least 10 working days before the effective date of the action.

(3) When the department conducts a hearing pursuant to ORS 416.310 to 416.340 and 416.510 to 416.830 and 416.990 or when the department proposes to deny, reduce, suspend or terminate a grant of general assistance, a grant of public assistance or a support service payment used to support participation in the job opportunity and basic skills program, the department shall provide an opportunity for a hearing under ORS chapter 183.

(4) When emergency assistance or the continuation of assistance pending a hearing on the reduction, suspension or termination of public assistance or a support service payment used to support participation in the job opportunity and basic skills program is denied, and the applicant for or recipient of public assistance or a support service payment requests a hearing on the denial, an expedited hearing on the denial shall be held within five working days after the request. A written decision shall be issued within three working days after the hearing is held.

(5) For purposes of this section, a reduction or termination of services resulting from an assessment for service eligibility as defined in ORS 411.099 is a grant of public assistance.

(6) If a coordinated care organization denies a medical assistance recipient a health service and the recipient requests a review of the denial, the department or the Oregon Health Authority must issue a notice no later than five business days after the recipient's request for review, affirming, reversing or modifying the denial of service.

[*(6)*] **(7)** Adoption of rules, conduct of hearings and issuance of orders and judicial review of rules and orders shall be in accordance with ORS chapter 183.

SECTION 10. ORS 414.625 is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the criteria for a coordinated care organization and shall integrate the criteria 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 adopted by the authority under this section must be designed so that:

(a) Each member of the coordinated care organization receives integrated person centered **physical, mental and dental health** 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 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, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established by the authority under ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604.

(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.

(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 [*includes representatives of the community and of county government, but with consumers making up a majority of the membership, and that meets regularly to ensure that the health care needs of the consumers and the community are being addressed*] **meets the criteria specified in section 2 of this 2012 Act**.

(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 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, 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 [*identified by the authority*] **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 442.210 (3).

(o) Each coordinated care organization has a governance structure that includes:

[*(A) A majority interest consisting of the persons that share in the financial risk of the organization;*]

[*(B) The major components of the health care delivery system; and*]

(A) At least three representative providers;

[*(C)*] **(B) 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**

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

(p) Each coordinated care organization maintains a network of providers sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the physical, mental and dental health care and services provided under the contract are reasonably accessible to the members of the organization.

(q) Each coordinated care organization contracts with or enters into an agreement with ambulatory surgical centers located in its service area and the contract or agreement includes a utilization plan to control costs and improve patient care.

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

(3) 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 11. ORS 414.635, as amended by section 9, chapter 602, Oregon Laws 2011, is amended to read:

414.635. (1) 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 and how to navigate the coordinated health care system.*]

[*(c) Must have access to advocates, including qualified peer wellness specialists where appropriate, 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) 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) 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) 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*] **services provided by the entity are** necessary for the organization to qualify as a coordinated care organization.

(5) 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. **The rate adopted by the authority that applies to a contracting health care entity shall be considered the reasonable cost for purposes of this subsection.**

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7) The authority shall [*maintain the process, approved by the Legislative Assembly,*] **adopt by rule a process** for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator.

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

(9) 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.

SECTION 12. ORS 414.638 is amended to read:

414.638. **(1) There is created a nine-member metrics and scoring committee appointed by the Governor and confirmed by the Senate in accordance with section 4, Article III of the Oregon Constitution. The members of the committee serve two-year terms and must include:**

(a) Three actuaries;

(b) Three individuals with expertise in health outcomes measures; and

(c) Three representatives of coordinated care organizations.

[*(1)*] **(2)** [*The Oregon Health Authority through a public process shall*] **The committee shall use a public process to** identify objective outcome and quality measures [*and benchmarks*], including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations. **Quality measures adopted by the committee must be consistent with existing state and national quality measures.** The **Oregon Health** Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements.

(3) The committee must adopt outcome and quality measures annually and adjust the measures to reflect:

(a) The amount of the global budget for a coordinated care organization;

(b) Changes in membership of the organization;

(c) The organization's costs for implementing outcome and quality measures; and

(d) The needs assessment and the costs of the needs assessment conducted by the organization under section 3 of this 2012 Act.

[*(2)*] **(4)** The authority shall evaluate on a regular and ongoing basis [*key*] **the outcome and** quality measures **adopted by the committee under this section**[*, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity,*] for members in each coordinated care organization and for members statewide.

[*(3)*] **(5)** [*Quality measures identified by the authority under this section must be consistent with existing state and national quality measures.*] The authority shall utilize available data systems for reporting **outcome and quality measures adopted by the committee** and take actions to eliminate any redundant reporting or reporting of limited value.

[*(4)*] **(6)** The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:

(a) Quality measures;

(b) Costs;

(c) Outcomes; and

(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.

SECTION 13. Section 14, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 14. (1) Notwithstanding ORS [*414.725 and 414.737*] **414.631 and 414.651**, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under [*sections 4, 6, 8, 10 and 12 of this 2011 Act and*] ORS 414.153, **414.625, 414.635, 414.638, 414.651, 414.655, 414.679,** 414.712, [*414.725,*] 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847 **and sections 1, 2 and 3 of this 2012 Act**.

(3) The authority may amend contracts that are in place on [*the effective date of this 2011 Act*] **July 1, 2011,** to allow prepaid managed care health services organizations that meet the criteria [*approved by the Legislative Assembly under section 13 of this 2011 Act*] **adopted by the authority under ORS 414.625** to become coordinated care organizations.

(4) The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on [*the effective date of this 2011 Act*] **July 1, 2011,** until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.

(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.

(6) Notwithstanding [*sections 4 (1)(g) and 6 (2) of this 2011 Act*] **ORS 414.625 (1)(g) and 414.655 (2)**, the authority shall allow for a period of transition to the full adoption of health information technology by coordinated care organizations and patient centered primary care homes. The authority shall explore options for assisting providers and coordinated care organizations in funding

their use of health information technology.

SECTION 14. Section 1 of this 2012 Act is repealed July 1, 2017.

SECTION 15. Section 8 of this 2012 Act is repealed on the date of the convening of the 2013 regular session of the Legislative Assembly as specified in ORS 171.010.

TECHNICAL CORRECTIONS AND CONFORMING AMENDMENTS

SECTION 16. 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) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(3) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for a category of aid but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years and:

(A) Is in a foster family home or licensed child-caring agency or institution and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part; or

(B) Is 18 years of age or older, is one for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A) of this paragraph immediately prior to the person's 18th birthday.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency

of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with developmental disabilities.

(k) Is under the age of 22 years and is in a psychiatric hospital.

(L) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(m) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(n) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(o) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(p) Is an individual or member of a group who, subject to the rules of the department or the Oregon Health Authority, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(r) Except as otherwise provided in this section, is a pregnant woman or child for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act.

(s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the department or the authority by rule, but whose family income is at or below the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department or the authority by rule.

(t) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (7).

(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

(v) Is dually eligible for Medicare and Medicaid and receiving care through a coordinated care organization.

(4) "Community health worker" means an individual 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.

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

(6) "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.

(7) "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.

(8) "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 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 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.

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

(10) "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.

(11) "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.

(12) "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. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(13) "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.

(14) "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

(15) "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.

(16) "Personal health navigator" means an individual 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.

(17) "Quality measure" means the **outcome and quality** measures [*and benchmarks identified by the authority*] **adopted** in accordance with ORS 414.638.

(18) "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.

SECTION 17. Section 62, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 62. [*(1)*] The Oregon Health Authority may not implement any [*provisions of this 2011 Act that require*] **provision of chapter 602, Oregon Laws 2011, that requires** federal approval**,** or that [*require*] **requires** federal approval to receive federal financial participation**,** until the authority has received the **federal** approval.

[*(2) Until the authority has received the approval of the Legislative Assembly under section 13 of this 2011 Act, the authority may not:*]

[*(a) Adopt by rule the qualification criteria for a coordinated care organization under section 4 of this 2011 Act or contract with a coordinated care organization;*]

[*(b) Adopt by rule a global budgeting process or establish global budgets for coordinated care organizations; or*]

[*(c) Implement a process for financial reporting by coordinated care organizations or establish financial reporting requirements under ORS 414.725 (1)(c).*]

SECTION 18. Section 63, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 63. The amendments to [*section 8 of this 2011 Act*] **ORS 414.635** by section 9 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** become operative [*January 1, 2014*] **on the effective date of this 2012 Act**.

SECTION 19. Section 64, chapter 602, Oregon Laws 2011, as amended by section 70, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 64. (1) ORS 414.705 is repealed.

(2) Sections 13[*, 14*] and 17 [*of this 2011 Act*]**, chapter 602, Oregon Laws 2011,** are repealed January 2, 2014.

(3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739 and 414.740 are repealed July 1, 2017.

(4) Section 14, chapter 602, Oregon Laws 2011, as amended by section 13 of this 2012 Act, is repealed July 1, 2017.

SECTION 20. ORS 414.033 is amended to read:

414.033. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from[,] the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project for:

(a) Providing medical assistance to individuals who are dually eligible for Medicare and Medicaid using [*alternative payment methodologies*] **a global budgeting process** or integrated and coordinated health care and services; or

(b) Evaluating service delivery systems.

SECTION 21. ORS 414.632 is amended to read:

414.632. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services [*under section 17, chapter 602, Oregon Laws 2011*], coordinated care organizations that meet the criteria adopted under ORS 414.625 are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) [*A*] Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved.

SECTION 22. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the Oregon Health Authority shall contract under

ORS 414.651 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by the Department of Consumer and Business Services as a health care service contractor to provide health services as described in ORS [*414.705 (1)(b)*] **414.025 (8)(b)**, (c), (d), (e), (g) and (j). A health plan may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS [*414.705 (1)(k)*] **414.025 (8)(k)** and (L). The authority may accept financial contributions from any public or private entity to help implement and administer the contract. The authority shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the authority shall contract with prepaid managed care health services organizations to provide health services under ORS 414.631, 414.651 and 414.688 to 414.750.

SECTION 23. ORS 416.540 is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise.

(2) The lien does not attach to the amount of any judgment, settlement or compromise to the extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment, settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by the recipient on account of the personal injuries for which the recipient had a claim.

(3) The authority may assign the lien described in subsection (1) of this section to a prepaid managed care health services organization or a coordinated care organization for medical costs incurred by a recipient:

(a) During a period for which the authority paid a capitation or enrollment fee or a payment using [*an alternative payment methodology*] **a global budgeting process**; and

(b) On account of the personal injury for which the recipient had a claim.

(4) A prepaid managed care health services organization or a coordinated care organization to which the authority has assigned a lien shall notify the authority no later than 10 days after filing notice of a lien.

(5) For the purposes of ORS 416.510 to 416.610, the authority may designate the prepaid managed care health services organization or the coordinated care organization to which a lien is assigned as its designee.

(6) If the authority and a prepaid managed care health services organization or a coordinated care organization both have filed a lien, the authority's lien shall be satisfied first.

SECTION 24. Sections 1 to 4 of this 2012 Act and ORS 414.631, 414.651 and 414.688 to 414.750 are added to and made a part of ORS chapter 414.

CAPTIONS

SECTION 25. The unit captions used in this 2012 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2012 Act.

EMERGENCY CLAUSE

SECTION 26. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.