A-Engrossed
Senate Bill 1580

Ordered by the Senate February 10
Including Senate Amendments dated February 10

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor John A. Kitzhaber for Oregon Health Authority)

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.

Provides legislative approval of Oregon Health Authority proposals for coordinated care organizations. Requires authority to report quarterly to legislative committees on implementation of coordinated care organization model of health care delivery **and other specified matters**. Authorizes sharing and use of information between Department of Consumer and Business Services and authority for specified purposes. Prohibits discrimination against types of providers by coordinated care organizations and specified managed care organizations.

Makes other changes to integrated and coordinated health care delivery system.

Requires Director of Oregon Health Authority to engage in appropriate state supervision for purpose of promoting state action immunity under state and federal antitrust laws.

Makes technical corrections.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care delivery; creating new provisions; amending ORS 414.033, 414.065, 414.625, 414.632, 414.635, 414.638, 414.740, 416.540 and 646.735 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:

LEGISLATIVE APPROVAL OF COORDINATED CARE ORGANIZATION PROPOSAL

SECTION 1. The Legislative Assembly approves the proposals presented by the Oregon Health Authority as required by section 13, chapter 602, Oregon Laws 2011.

SECTION 2. 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.

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.

(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 (2)(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 3. 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 4. 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 5. 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 appropri-

ate, 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 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.

(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.

IMPLEMENTATION OF OREGON INTEGRATED AND COORDINATED CARE DELIVERY SYSTEM

SECTION 6. (1) The Department of Consumer and Business Services and the Oregon

Health Authority may enter into agreements governing the disclosure of information reported to the department by insurers with certificates of authority to transact insurance in this state.

(2) The authority may use information disclosed under subsection (1) of this section for the purpose of carrying out ORS 414.625, 414.635, 414.638, 414.645 and 414.651.

SECTION 7. Section 8 of this 2012 Act is added to and made a part of ORS chapter 414.

SECTION 8. (1) A fully capitated health plan, physician care organization or coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. A plan or organization must give written notice containing the reasons for its action if the plan or organization declines the participation of any provider or group of providers.

(2) Subsection (1) of this section does not:

(a) Require a plan or organization to contract with more providers than are necessary to meet the needs of its members;

(b) Preclude the plan or organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or

(c) Preclude the plan or organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the plan's or organization's responsibilities to its members.

(3) A plan or organization may establish an internal review process for a provider aggrieved under this section, including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Oregon Health Authority.

(4) The authority shall adopt by rule a process for resolving claims of discrimination under this section and, in making a determination of whether there has been discrimination, must consider the plan's or organization's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(5) A prevailing party in an appeal under this section shall be awarded the costs of the appeal.

SECTION 9. Section 8 of this 2012 Act is amended to read:

Sec. 8. (1) A [*fully capitated health plan, physician care organization or*] coordinated care organization may not discriminate in the participation or reimbursement of any health care provider based on the provider's license or certification if the provider is acting within the scope of the provider's license or certification. [*A plan or*] **An** organization must give written notice containing the reasons for its action if the [*plan or*] organization declines the participation of any provider or group of providers.

(2) Subsection (1) of this section does not:

(a) Require [*a plan or*] **an** organization to contract with more providers than are necessary to meet the needs of its members;

(b) Preclude the [*plan or*] organization from using different reimbursement amounts for different specialties or different practitioners in the same specialty; or

(c) Preclude the [*plan or*] organization from establishing measures that are designed to maintain the quality of services and control costs and are consistent with the [*plan's or*] organization's responsibilities to its members.

(3) [*A plan or*] **An** organization may establish an internal review process for a provider aggrieved under this section, including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Oregon Health Authority.

(4) The authority shall adopt by rule a process for resolving claims of discrimination under this section and, in making a determination of whether there has been discrimination, must consider the [*plan's or*] organization's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(5) A prevailing party in an appeal under this section shall be awarded the costs of the appeal.

SECTION 10. The amendments to section 8 of this 2012 Act by section 9 of this 2012 Act become operative July 1, 2017.

SECTION 11. In each calendar quarter, the Oregon Health Authority shall report to the appropriate committees or interim committees of the Legislative Assembly:

(1) On the implementation of the Oregon Integrated and Coordinated Care Delivery System;

(2) On the progress in implementing an arbitration process in accordance with ORS 414.635 (7);

(3) For the purpose of developing a baseline with which to compare future costs, per member costs for each category of service; and

(4) The administrative costs to the authority in the implementation of the system and the aggregate financial information reported to the authority by coordinated care organizations, including but not limited to the coordinated care organizations':

(a) Payments for each category of service as prescribed by the authority; and

(b) Reserves, projected cash flows and other financial information prescribed by the authority by rule.

SECTION 12. Section 11 of this 2012 Act is repealed July 1, 2017.

SECTION 13. (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 government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership;

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

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

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

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

(b) Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and

(c) Annually publishing a report on the progress of the community health improvement plan.

(3) The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; and

(f) Workforce development.

SECTION 14. (1) Upon the request of a coordinated care organization, the Oregon Health Authority shall assign to the 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 coordinated care organization and the authority. The organization may provide a work space to enable the agent to be colocated at a site of the coordinated care organization if practical.

(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.

(4) The innovator agent shall be made available by the authority for a period of four years beginning on the date that the coordinated care organization first contracts with the authority to be a coordinated care organization. Upon the request of the coordinated care organization, the authority may extend the period.

SECTION 15. Section 16 of this 2012 Act is added to and made a part of ORS 192.553 to 192.581.

SECTION 16. (1) Notwithstanding ORS 179.505, a health care provider that is a participant in a coordinated care organization, as defined in ORS 414.025, shall disclose protected health information:

(a) To other health care providers participating in the coordinated care organization for treatment purposes, and to the coordinated care organization for health care operations and payment purposes, as permitted by ORS 192.558; and

(b) To public health entities as required for health oversight purposes.

(2) The disclosures described in subsection (1) of this section may be provided without the authorization of the patient or the patient's personal representative.

(3) Subsection (1) of this section does not apply to psychotherapy notes, as defined in ORS 179.505.

SECTION 17. (1) The work group on Patient Safety and Defensive Medicine is established, consisting of eight members appointed as follows:

(a) The President of the Senate shall appoint two members from among members of the Senate as follows:

(A) One member from the Democratic party.

(B) One member recommended by the leadership of the Republican party in the Senate.

(b) Each Co-Speaker of the House of Representatives shall appoint one member from among members of the House of Representatives.

(c) The Governor shall appoint four members, including:

(A) At least one member who is a physician licensed under ORS chapter 677 and in active practice; and

(B) At least one member who is a trial lawyer.

(2) Under the direction of the Governor, the work group shall recommend legislation to be introduced in the 2013 regular session of the Legislative Assembly to improve health care delivery in this state and to reduce medical errors. The work group shall prioritize legislation that:

(a) Improves patient safety;

(b) More effectively compensates individuals who are injured as a result of medical errors; and

(c) Reduces the collateral costs associated with the medical liability system, including the costs associated with insurance administration, litigation and defensive medicine.

(3) A majority of the voting members of the work group constitutes a quorum for the transaction of business.

(4) Official action by the work group requires the approval of a majority of the voting members of the work group.

(5) The Governor shall select one member of the work group to serve as chairperson and another to serve as vice chairperson, for the terms and with the duties and powers necessary for the performance of the functions of such offices as the Governor determines.

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

(7) Members of the Legislative Assembly appointed to the work group are nonvoting members of the work group and may act in an advisory capacity only.

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

(9) The work group may adopt rules necessary for the operation of the work group.

(10) The work group shall submit its recommendations for legislation to the interim committees of the Legislative Assembly related to health care no later than October 1, 2012.

(11) The Oregon Health Authority shall provide staff support to the work group.

(12) Members of the work group who are not members of the Legislative Assembly 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 incurred in performing functions of the work group shall be paid out of funds appropriated to Oregon Health Authority for purposes of the work group.

(13) All agencies of state government, as defined in ORS 174.111, are directed to assist

the work group 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 work group consider necessary to perform their duties.

SECTION 18. Section 17 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.

SECTION 19. ORS 414.065 is amended to read:

414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

(A) The types and extent of health care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards, including outcome and quality measures, to be observed in the provision of health care and services.

(C) The number of days of health care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of health care or services.

(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of health care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of health care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all health care and services for which such payments of medical assistance were made.

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

(5) In determining a global budget for a coordinated care organization:

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

(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs.

(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

(a) To support improved delivery of health care to recipients of medical assistance; and

(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

SECTION 20. ORS 414.625 is amended to read:

414.625. (1) The Oregon Health Authority shall adopt by rule the **qualification** criteria **and requirements** for a coordinated care organization and shall integrate the criteria **and requirements** into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must [*be designed*] **include, but are not limited to, the coordinated care organization's demonstrated experience and capacity for:**

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

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

(c) Operating within a fixed global budget.

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) Engaging 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 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 **or other models that support patient centered primary 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, 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 possi-

ble and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

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

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

(i) Each coordinated care organization convenes a community advisory council that [*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 13 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 **who must constitute a majority of the governance structure**;

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

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

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

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

[*(C)*] **(D) 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**

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

[*(2)*] **(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.

[*(3)*] **(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 21. ORS 414.638 is amended to read:

414.638. **(1) There is created a nine-member metrics and scoring committee appointed by the Director of the Oregon Health Authority. The members of the committee serve two-year terms and must include:**

(a) Three members at large;

(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 community health assessment and the costs of the community health assessment conducted by the organization under section 13 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 22. ORS 646.735 is amended to read:

646.735. (1) The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, coordinated care organizations that might otherwise be constrained by such laws. [*The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers as to the prices of specific health services.*]

(2) The Director of the Oregon Health Authority or the director's designee [*may*] **shall** engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the Oregon Integrated and Coordinated Health Care Delivery System established under ORS 414.620 is implemented in accordance with the legislative intent expressed in ORS 414.018.

(3) [*The Oregon Health Authority may convene*] Groups that include, but are not limited to, health insurance companies, health care centers, hospitals, health service organizations, employers, health care providers, health care facilities, state and local governmental entities and consumers, **may meet** to facilitate the development**,** [*and establishment of the Oregon Integrated and Coordinated Health Care Delivery System and health care payment reforms*] **implementation and operation of a coordinated care organization in accordance with criteria and requirements adopted by the Oregon Health Authority under ORS 414.625**. Any participation by such entities and individuals shall be on a voluntary basis.

(4) The authority may[:]

[*(a)*] conduct a survey of the entities and individuals specified in subsection (3) of this section concerning payment and delivery reforms[*; and*]

[*(b) Convene meetings at a time and place that is convenient for the entities and individuals specified in subsection (3) of this section*].

(5) A survey or meeting under subsection **(3) or** (4) of this section is not a violation of state antitrust laws and shall be considered state action for purposes of federal antitrust laws through the state action doctrine.

TECHNICAL CORRECTIONS AND CONFORMING AMENDMENTS

SECTION 23. 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 2 of this 2012 Act, is repealed July 1, 2017.

SECTION 24. 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 **global or** alternative payment methodologies or integrated and coordinated health care and services; or

(b) Evaluating service delivery systems.

SECTION 25. 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 26. 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 27. 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*] **a global** payment methodology; 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 28. ORS 414.631, 414.651 and 414.688 to 414.750 are added to and made a part of ORS chapter 414.

CAPTIONS

SECTION 29. 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 30. 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.
