HB 3309-5
(LC 2931)
5/29/13 (LHF/ps)

PROPOSED AMENDMENTS TO HOUSE BILL 3309

On page 1 of the printed bill, delete lines 5 through 22 and insert:

"SECTION 1. (1) As used in this section:

"(a) 'Community' means Marion and Polk Counties.

"(b) 'Essential health care entity' means a hospital, a health care provider or an organization of health care providers:

"(A) That, with respect to a specified health service, is the sole provider of that service in the community;

"(B) That, in the case of a hospital or organization of health care providers, includes more than 25 percent of the health care providers in a specified area of practice in the community; or

"(C) Whose action, refusal to act or withdrawal from a coordinated care organization puts at risk a coordinated care organization's certification under ORS 414.625.

"(2) The Oregon Health Authority shall conduct a pilot project in Marion and Polk Counties. In the pilot project:

"(a) An essential health care entity may not:

"(A) Refuse to provide health care to a member of a coordinated care organization;

"(B) Refuse to contract or cooperate with a coordinated care organization;

"(C) Initiate a legal action against a coordinated care organization to recover a rate of reimbursement that exceeds the reimbursement

specified in ORS 414.743; or

"(D) Act or refuse to act in a manner that puts at risk a coordinated care organization's certification under ORS 414.625.

"(b) Any claim by a coordinated care organization that an essential health care entity has failed to comply with paragraph (a) of this subsection shall be adjudicated by the Oregon Health Authority in a contested case proceeding under ORS chapter 183. The essential health care entity subject to the claim shall be a party to the proceedings.

"(c) If the authority determines that an essential health care entity has failed to comply with paragraph (a) of this subsection:

"(A) For the 12-month period following the determination, any reimbursement paid for services provided by the essential health care entity to a member of the coordinated care organization that brought the claim under paragraph (b) of this subsection shall be the least of:

"(i) Sixty percent of the reimbursement paid by Medicare;

"(ii) The reimbursement paid under ORS 414.743, if the essential health care entity is a hospital; and

"(iii) The fee-for-service reimbursement established by the authority under ORS 414.065; and

"(B) For the five-year period following the determination, the essential health care entity may not create a coordinated care organization or participate in the governing body of a coordinated care organization.

"(d) The Attorney General may take any legal action necessary to enforce the conditions of the pilot project.

"SECTION 2. No later than 12 months after the effective date of this 2013 Act, the Oregon Health Authority shall report to the House Interim Committee on Health Care in the manner prescribed by ORS 192.245:

"(1) The results of the pilot project described in section 1 of this 2013 Act;

"(2) Recommendations for legislative changes to the pilot project; and

"(3) Recommendations for expanding the pilot project statewide.

"SECTION 3. Section 4 of this 2013 Act is added to and made a part of ORS 243.105 to 243.285.

"SECTION 4. The Public Employees' Benefit Board may contract with a coordinated care organization to provide health care to eligible employees if the coordinated care organization has:

"(1) A certificate of authority from the Director of the Department of Consumer and Business Services to transact insurance; and

"(2) Provided health care to recipients of medical assistance who reside in the geographic area served by the coordinated care organization for a period of at least 12 months.

"SECTION 5. Section 6 of this 2013 Act is added to and made a part of ORS 243.860 to 243.886.

"SECTION 6. The Oregon Educators Benefit Board may contract with a coordinated care organization to provide health care to eligible employees if the coordinated care organization has:

"(1) A certificate of authority from the Director of the Department of Consumer and Business Services to transact insurance; and

"(2) Provided health care to recipients of medical assistance who reside in the geographic area served by the coordinated care organization for a period of at least 12 months.".

In line 23, delete "3" and insert "7".

On page 3, line 30, delete "as provided" and insert "for coordinated care organizations participating in the pilot project described" and delete "2" and insert "1".

In line 31, delete "board of directors" and insert "governing body".

In line 33, delete "board" and insert "governing body".

On page 4, line 8, delete "4" and insert "8".

On page 5, delete lines 13 through 16 and insert:

"(c) Decertify a coordinated care organization that substantially fails to comply with rules adopted pursuant to ORS 414.625 or this section.".

In line 17, delete "5" and insert "9".

On page 8, line 45, delete "6" and insert "10".

On page 9, line 16, delete "7" and insert "11".

After line 42, insert:

"**SECTION 12.** ORS 414.625, as amended by section 20, chapter 8, Oregon Laws 2012, and section 7 of this 2013 Act, is amended to read:

"414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for the certification of 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 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 certification 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 possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

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

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

"(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in section 13, chapter 8, Oregon Laws 2012.

"(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 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) [*Except for coordinated care organizations participating in the pilot project described in section 1 of this 2013 Act,*] Each coordinated care organization has a governing body that includes:

"(A) Individuals representing the health care entities that share in the financial risk of the organization who must constitute a majority of the governing body;

"(B) Individuals representing the major components of the health care delivery system;

"(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;

"(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.

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

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

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

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

"(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

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

"SECTION 13. The amendments to ORS 414.625 by section 12 of this 2013 Act become operative January 2, 2018.

"SECTION 14. Sections 1 and 2 of this 2013 Act are repealed January 2, 2018.".

In line 43, delete "8" and insert "15".
