77th OREGON LEGISLATIVE ASSEMBLY--2013 Regular Session

Senate Bill 459

Sponsored by Senator BATES

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.**

Requires coordinated care organization to establish grievance procedure for providers and health care entities participating or wishing to participate in organization to dispute decisions made by organization. Requires organization to utilize standardized and equitable methodology for assigning patients to providers and health care entities. Requires organization to provide oral health care through contracts with dental care organizations unless no dental care organization provides care in geographic area served by coordinated care organization.

1 **A BILL FOR AN ACT**

2 Relating to coordinated care organizations; amending ORS 414.625.

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

4 **SECTION 1.** ORS 414.625, as amended by section 20, chapter 8, Oregon Laws 2012, is amended
5 to read:

6 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
7 quirements for a coordinated care organization and shall integrate the criteria and requirements
8 into each contract with a coordinated care organization. Coordinated care organizations may be
9 local, community-based organizations or statewide organizations with community-based participation
10 in governance or any combination of the two. Coordinated care organizations may contract with
11 counties or with other public or private entities to provide services to members. The authority may
12 not contract with only one statewide organization. A coordinated care organization may be a single
13 corporate structure or a network of providers organized through contractual relationships. The cri-
14 teria adopted by the authority under this section must include, but are not limited to, the coordi-
15 nated care organization's demonstrated experience and capacity for:

16 (a) Managing financial risk and establishing financial reserves.

17 (b) Meeting the following minimum financial requirements:

18 (A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the coor-
19 dinated care organization's total actual or projected liabilities above $250,000.

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

22 (c) Operating within a fixed global budget.

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

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

27 (f) Engaging community members and health care providers in improving the health of the
28 community and addressing regional, cultural, socioeconomic and racial disparities in health care
29 that exist among the coordinated care organization's members and in the coordinated care

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.

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

(A) 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;

(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.

(p) Each organization provides a written grievance process, which may be utilized by any provider or health care entity participating or desiring to participate in the coordinated care organization, that:

(A) Provides a meaningful opportunity for the provider or health care entity to contest decisions of the organization, including but not limited to decisions regarding:

(i) Payments for services;

(ii) Requirements for participation in the organization;

(iii) Exclusion from participation in the organization; and

(iv) Termination of participation in the organization;

(B) Is conducted and decided by a person who is not employed by or affiliated with the organization and does not have a conflict of interest; and

(C) Complies with any other requirements prescribed by the authority by rule.

(q) Each organization utilizes a standardized and equitable methodology to assign patients to participating providers and health care entities and the methodology is:

(A) Approved by the authority;

(B) In writing; and

(C) Available to any provider or health care entity upon request.

(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] **provide oral health care to the members of the organization through formal contracts with all of the dental care organizations that provide oral health care in the geographic area served by the coordinated care organization. A coordinated care organization may provide oral health care to its members through its own network of providers if there is no dental care organization providing oral health care in the geographic area**.