SB 440-1
(LC 1460)
3/10/15 (LHF/ps)

PROPOSED AMENDMENTS TO
SENATE BILL 440

On page 1 of the printed bill, line 3, delete the first "and" and insert a comma and after "414.685" insert ", 417.721 and 442.466".

On page 2, line 21, delete "and".

Delete lines 22 through 41 and insert:

"(D) An individual appointed by the Department of Consumer and Business Services; and

"(E) Individuals appointed by the Oregon Health Policy Board in collaboration with the Oregon Educators Benefit Board, the Public Employees' Benefit Board and the Department of Consumer and Business Services including:

"(i) Two health care providers;

"(ii) One individual to represent insurers, large employers or multiple employer welfare arrangements;

"(iii) Two individuals representing health care consumers; and

"(iv) Two individuals representing coordinated care organizations.

"(b) The committee shall work collaboratively with the Oregon Educators Benefit Board and the Public Employees' Benefit Board to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers and consumers. The committee shall be the single body to align the requirements of health care data reporting and use with the health outcome and quality measures used in this state to ensure that the requirements and the measures are co-

ordinated, evidence-based and focused on a long term statewide vision.

"(c) The committee shall use a public process to identify the health outcome and quality measures, including measures for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations and in health benefit plans offered by the Oregon Educators Benefit Board and the Public Employees' Benefit Board. Quality measures adopted by the committee must be consistent with existing state and national quality measures including measures adopted by the Centers for Medicare and Medicaid Services.

"(d) The Oregon Health Authority shall incorporate the health outcome and quality measures adopted under this section into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

"(e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality measures adopted under this section.

"(f) The committee, in coordination with the Office for Oregon Health Policy and Research, shall streamline the health outcome and quality measure data that must be reported to the committee and eliminate redundant reporting or reporting of data with limited value.

"(g) The committee shall publish the health outcome and quality measure data collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan offered by the Oregon Educators Benefit Board and the Public Employees' Benefit Board:

"(A) Quality measures;

"(B) Costs;

"(C) Health outcomes; and

"(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by a coordinated care organization and by each health benefit plan.

"(h) The committee may convene subcommittees to focus on gaining expertise in particular areas such as data collection, health care research and mental health and substance use disorders in order to aid the committee in the development of health outcome and quality measures. A subcommittee may include staff from the Oregon Health Authority, the Department of Human Services, the Department of Consumer and Business Services, the Early Learning Council or any other agency staff with the appropriate expertise in the issues addressed by the subcommittee.".

On page 3, after line 1, insert:

"SECTION 2. (1) The metrics and scoring committee appointed by the Director of the Oregon Health Authority is abolished. On the operative date of this section, the tenure of the members of the metrics and scoring committee ceases.

"(2) All the duties, functions and powers of the metrics and scoring committee are imposed upon, transferred to and vested in the Health Plan Quality Metrics Committee described in ORS 413.017.

"(3) Nothing in this section or the repeal of ORS 414.638 by section 13 of this 2015 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by this section. The Health Plan Quality Metrics Committee is substituted for and a continuation of the metrics and scoring committee.".

In line 2, delete "2" and insert "3".

In line 37, delete "3" and insert "4".

On page 4, line 29, delete "4" and insert "5".

In line 35, delete "5" and insert "6".

On page 7, delete lines 2 through 45.

Delete page 8.

On page 9, delete lines 1 through 14 and insert:

"**SECTION 7.** 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 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 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 ORS 414.627.

"(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[,] **and** objective quality information and are removed if the providers fail to meet objective quality standards.

"(G) Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

"(L) Each coordinated care organization reports on **health** outcome and quality measures adopted [*under ORS 414.638*] **by the Health Plan Quality Metrics Committee under ORS 413.017** 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 governing body that includes:

"(A) Persons that share in the financial risk of the organization who must constitute a majority of the governing body;

"(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 coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization

and the organization's community advisory councils, as necessary, to keep the community informed.

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

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

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

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

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

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

In line 15, delete "7" and insert "8".

In line 44, delete "8" and insert "9".

On page 10, after line 6, insert:

"SECTION 10. ORS 417.721 is amended to read:

"417.721. The Oregon Health Authority**, the Health Plan Quality Metrics Committee** and the Early Learning Council shall work collaboratively with coordinated care organizations to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes.

"SECTION 11. ORS 442.466 is amended to read:

"442.466. (1) The Administrator of the Office for Oregon Health Policy and Research shall establish and maintain a program that requires reporting en-

tities to report health care data for the following purposes:

"(a) Determining the maximum capacity and distribution of existing resources allocated to health care.

"(b) Identifying the demands for health care.

"(c) Allowing health care policymakers to make informed choices.

"(d) Evaluating the effectiveness of intervention programs in improving health outcomes.

"(e) Comparing the costs and effectiveness of various treatment settings and approaches.

"(f) Providing information to consumers and purchasers of health care.

"(g) Improving the quality and affordability of health care and health care coverage.

"(h) Assisting the administrator in furthering the health policies expressed by the Legislative Assembly in ORS 442.025.

"(i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity.

"(2) The Administrator of the Office for Oregon Health Policy and Research**, in coordination with the Health Plan Quality Metrics Committee,** shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that:

"(a) Establish the time, place, form and manner of reporting data under this section, including but not limited to:

"(A) Requiring the use of unique patient and provider identifiers;

"(B) Specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to Oregon residents in other states; and

"(C) Establishing enrollment thresholds below which reporting will not be required.

"(b) Establish the types of data to be reported under this section, including but not limited to:

"(A) Health care claims and enrollment data used by reporting entities and paid health care claims data;

"(B) Reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the administrator to be necessary to carry out the purposes of this section; and

"(C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards.

"(3) Any third party administrator that is not required to obtain a license under ORS 744.702 and that is legally responsible for payment of a claim for a health care item or service provided to an Oregon resident may report to the Administrator of the Office for Oregon Health Policy and Research the health care data described in subsection (2) of this section.

"(4) The Administrator of the Office for Oregon Health Policy and Research shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.

"(5) The Administrator of the Office for Oregon Health Policy and Research shall use data collected under this section to provide information to consumers of health care to empower the consumers to make economically sound and medically appropriate decisions. The information must include, but not be limited to, the prices and quality of health care services.

"(6) The Administrator of the Office for Oregon Health Policy and Research may contract with a third party to collect and process the health care data reported under this section. The contract must prohibit the collection of Social Security numbers and must prohibit the disclosure or use of the data for any purpose other than those specifically authorized by the contract. The contract must require the third party to transmit all data collected and processed under the contract to the Office for Oregon Health Policy and

Research.

"(7) The Administrator of the Office for Oregon Health Policy and Research shall facilitate a collaboration between the Department of Human Services, the Oregon Health Authority, the Department of Consumer and Business Services and interested stakeholders to develop a comprehensive health care information system using the data reported under this section and collected by the office under ORS 442.120 and 442.400 to 442.463. The administrator, in consultation with interested stakeholders, shall:

"(a) Formulate the data sets that will be included in the system;

"(b) Establish the criteria and procedures for the development of limited use data sets;

"(c) Establish the criteria and procedures to ensure that limited use data sets are accessible and compliant with federal and state privacy laws; and

"(d) Establish a time frame for the creation of the comprehensive health care information system.

"(8) Information disclosed through the comprehensive health care information system described in subsection (7) of this section:

"(a) Shall be available, when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal laws, as a resource to insurers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures and performance in this state;

"(b) Shall be available to Oregon programs for quality in health care for use in improving health care in Oregon, subject to rules prescribed by the Administrator of the Office for Oregon Health Policy and Research conforming to state and federal privacy laws or limiting access to limited use data sets;

"(c) Shall be presented to allow for comparisons of geographic, demographic and economic factors and institutional size; and

"(d) May not disclose trade secrets of reporting entities.

"(9) The collection, storage and release of health care data and other information under this section is subject to the requirements of the federal Health Insurance Portability and Accountability Act.".

In line 7, delete "9" and insert "12".

In line 34, delete "10" and insert "13".

In line 35, delete "11." and insert "14. (1)".

In line 38, delete "2016" and insert "2018".

Delete lines 39 through 41 and insert:

"(2) The members of the Health Plan Quality Metrics Committee shall be appointed no later than February 1, 2017.

"SECTION 15. Section 2 of this 2015 Act, the amendments to ORS 243.135, 243.866, 413.017, 413.181, 414.025, 414.625, 414.679, 414.685, 417.721 and 442.466 and section 14, chapter 602, Oregon Laws 2011, by sections 1 and 3 to 12 of this 2015 Act and the repeal of ORS 414.638 by section 13 of this 2015 Act become operative February 1, 2017.

"SECTION 16. (1) The Oregon Health Policy Board, the Oregon Health Authority, the Oregon Educators Benefit Board and the Public Employees' Benefit Board shall take any action before the operative date specified in section 15 of this 2015 Act that is necessary for the boards and the authority to exercise, on and after the operative date specified in section 15 of this 2015 Act, all of the duties functions and powers conferred on the boards and the authority by section 2 of this 2015 Act and the amendments to ORS 243.135, 243.866, 413.017, 413.181, 414.025, 414.625, 414.679, 414.685, 417.721 and 442.466 and section 14, chapter 602, Oregon Laws 2011, by sections 1 and 3 to 12 of this 2015 Act.

"(2) The Oregon Health Policy Board, the Oregon Health Authority, the Oregon Educators Benefit Board and the Public Employees' Benefit Board shall take any action before the date specified in section 14 (1) of this 2015 Act that is necessary for the boards and the authority

to implement the health outcome and quality measures described in ORS 413.017 (4) on and after the date specified in section 14 (1) of this 2015 Act.".

In line 42, delete "13" and insert "16".
