B-Engrossed
House Bill 2122

Ordered by the House May 16
Including House Amendments dated April 19 and May 16

Sponsored by Representative GREENLICK; Representative HOLVEY (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.

Modifies requirements for coordinated care organizations. **Requires governing body to take specific steps to provide more transparency.** Makes all meetings of [*governing body of coordinated care organization and*] community advisory council subject to open meetings law and requires coordinated care organization to spend **portion of** earnings above specified threshold on services designed to address health disparities and social determinants of health **in accordance with rules adopted with stakeholder rules advisory committee**. Requires [*new*] coordinated care organizations [*and coordinated care organizations that transfer ownership to new entity*] to be community-based tax exempt organizations **or public benefit corporations beginning January 1, 2023**. **Requires coordinated care organizations to annually report to Oregon Health Authority, to be published on authority's website, financial information and information about activities of governing body and community advisory council.**

Requires authority to develop plan for moving coordinated care organizations toward greater utilization of alternative payment methodologies by December 31, 2023.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; amending ORS 414.025, 414.625, 414.627 and 414.653; and declaring an emergency.

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

SECTION 1. 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 **and requirements** adopted by the authority under this section must include, but are not limited to, **a requirement that** the coordinated care [*organization's demonstrated experience and capacity for*] **organization**:

(a) **Have demonstrated experience and a capacity for** managing financial risk and establishing financial reserves.

(b) [*Meeting*] **Meet** the following minimum financial requirements:

(A) [*Maintaining*] **Maintain** 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.

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.

(B) [*Maintaining*] **Maintain** 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) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements of this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) [*Operating*] **Operate** within a fixed global budget.

(d) [*Developing and implementing*] **Develop and implement** alternative payment methodologies that are based on health care quality and improved health outcomes.

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

(f) [*Engaging*] **Engage** 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 **and requirements** 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, behavioral health homes or other models that support patient centered primary care and behavioral health 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 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 413.259 (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**, appointed by the council, who is a current or former member of a coordinated care organization**.

(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. **The standards must include all requirements applicable to written minutes in ORS 192.650 and the minutes must be easily accessible on the coordinated care organization's website.**

(q) The governing body of each coordinated care organization has a mechanism in place to ensure that activities of the governing body are regularly reported to the community ad-

visory council of the coordinated care organization.

(r) Each coordinated care organization makes publicly available the name and contact information for the chairperson of the governing body and either a member of the community advisory council or a designated employee of the coordinated care organization.

(s) The governing body of each coordinated care organization holds at least one meeting jointly with its community advisory council each year that is open to the public.

(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 2. ORS 414.625, as amended by section 1 of this 2017 Act, 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. **A coordinated care organization must be:**

(a) Recognized as tax exempt under section 501(c)(3) of the Internal Revenue Code of 1986; or

(b) A public benefit corporation as defined in ORS 65.001.

(2) The criteria and requirements adopted by the authority under **subsection (1) of** this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain 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) Maintain 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) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements of this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget.

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

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

(f) Engage 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)*] **(3)** In addition to the criteria and requirements specified in subsection [*(1)*] **(2)** 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, behavioral health homes or other models that support patient centered primary care and behavioral health 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 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 413.259 (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, appointed by the council, who is a current or former member of a coordinated care organization.

(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 to keep the community informed. The standards must include all requirements applicable to written minutes in ORS 192.650 and the minutes must be easily accessible on the coordinated care organization's website.

(q) The governing body of each coordinated care organization has a mechanism in place to ensure that activities of the governing body are regularly reported to the community advisory council of the coordinated care organization.

(r) Each coordinated care organization makes publicly available the name and contact information for the chairperson of the governing body and either a member of the community advisory council or a designated employee of the coordinated care organization.

(s) The governing body of each coordinated care organization holds at least one meeting jointly with its community advisory council each year that is open to the public.

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

[*(4)*] **(5)** 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)*] **(6)** [*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 3. In the adoption of rules to implement the amendments to ORS 414.625 (1)(b)(C) by section 1 of this 2017 Act, the Oregon Health Authority shall:

(1) Convene a rules advisory committee under ORS 183.333 that includes one representative from each of the coordinated care organizations and other stakeholders;

(2) Take into consideration:

(a) The variability of coordinated care organizations' operating budgets;

(b) The obligations and investments of coordinated care organizations;

(c) The variability in risk-sharing arrangements between coordinated care organizations; and

(d) The needed investments in infrastructure improvements that coordinated care organizations must make to ensure the long term viability of the coordinated care organizations' ability to provide services; and

(3) Consult with the Department of Consumer and Business Services with respect to financial requirements imposed on a coordinated care organization that is regulated by the department.

SECTION 4. Section 5 of this 2017 Act is added to and made a part of ORS chapter 414.

SECTION 5. (1) Coordinated care organizations shall report annually to the Oregon Health Authority:

(a) Financial information prescribed by the authority that discloses each coordinated care organization's profit margin, medical and nonmedical costs, investments and payments made to partner organizations; and

(b) The activities of the governing body and the community advisory council for each coordinated care organization.

(2) The authority shall publish the information reported under this section on the authority's website.

SECTION 6. ORS 414.627 is amended to read:

414.627. (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; and

(b) 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.

(4) The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(5) If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:

(a) That are open to the public and attended by the members of the council;

(b) At which the council shall report on the activities of the coordinated care organization and the council;

(c) At which the council shall provide written reports on the activities of the coordinated care organization; and

(d) At which the council shall provide the opportunity for the public to provide written or oral comments.

(6) The coordinated care organization shall post to the organization's website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.

(7) Meetings of the council are [*not*] subject to ORS 192.610 to 192.690.

SECTION 7. ORS 414.025, as amended by section 9, chapter 389, Oregon Laws 2015, 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) "Behavioral health clinician" means:

(a) A licensed psychiatrist;

(b) A licensed psychologist;

(c) A certified nurse practitioner with a specialty in psychiatric mental health;

(d) A licensed clinical social worker;

(e) A licensed professional counselor or licensed marriage and family therapist;

(f) A certified clinical social work associate;

(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

(3) "Behavioral health home" means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

(4) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

(5) "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.

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

(7) "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.

(8) "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.

(9) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange

described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(10) "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.

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

(12)(a) "Integrated health care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

(A) Mental illness.

(B) Substance use disorders.

(C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, "other care team members" includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the Oregon Health Authority.

(13) "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.

(14) "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.

(15) "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. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care or services for a resident of a nonmedical public institution.

(16) "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.

(17) "Peer support specialist" means any of the following individuals who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment;

(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder; or

(c) A family member of a current or former consumer of mental health or addiction treatment.

(18) "Peer wellness specialist" means an individual who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(19) "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.

(20) "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.

(21) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654

or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(22) "Quality measure" means the health outcome and quality measures and benchmarks identified by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

(23) "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.

(24) "Social determinants of health" means the conditions in which individuals are born, grow, live, work and age, including but not limited to food, safe housing, economic opportunities, health care, transportation and education.

(25) "Transformation plan" means the terms in a contract between the authority and a coordinated care organization that specify the benchmarks that the coordinated care organization must meet in order to comply with the provisions of ORS 414.625.

SECTION 8. ORS 414.653 is amended to read:

414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes and behavioral health homes.

(2) The authority shall [*encourage*] **work with each** coordinated care [*organizations to utilize*] **organization to develop individual plans to move each coordinated care organization toward greater utilization of** alternative payment methodologies [*that move from a predominantly fee-for-service system to payment methods*] that base reimbursement on the quality rather than the quantity of services provided. **Each plan must:**

(a) Describe how coordinated care organizations and contracted providers will, by December 31, 2023, meet benchmarks established by the authority in the use of alternative payment methodologies to reimburse providers;

(b) Provide a broad definition of alternative payment methodologies that aligns with the payment models developed by the Center for Medicaid and Medicare Innovation; and

(c) Allow a coordinated care organization to phase in the use of alternative payment methodologies over the term of the coordinated care organization's contract with the authority.

(3) The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

(4) If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with priv-

ileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

(5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

(6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

SECTION 9. ORS 414.653, as amended by section 8 of this 2017 Act, is amended to read:

414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes and behavioral health homes.

[*(2) The authority shall work with each coordinated care organization to develop individual plans to move each coordinated care organization toward greater utilization of alternative payment methodologies that base reimbursement on the quality rather than the quantity of services provided. Each plan must:*]

[*(a) Describe how coordinated care organizations and contracted providers will, by December 31, 2023, meet benchmarks established by the authority in the use of alternative payment methodologies to reimburse providers;*]

[*(b) Provide a broad definition of alternative payment methodologies that aligns with the payment*

models developed by the Center for Medicaid and Medicare Innovation; and]

[*(c) Allow a coordinated care organization to phase in the use of alternative payment methodologies over the term of the coordinated care organization's contract with the authority.*]

[*(3)*] **(2)** The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

[*(4)*] **(3)** If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

[*(5)(a)*] **(4)(a)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

[*(6)*] **(5)** Notwithstanding [*subsections (1) and (2)*] **subsection (1)** of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

SECTION 10. The amendments to ORS 414.025, 414.625, 414.627 and 414.653 by sections 1 and 6 to 8 of this 2017 Act apply:

(1) To coordinated care organizations that have contracts with the Oregon Health Authority on the effective date of this 2017 Act.

(2) Beginning on the effective date of the next contract between the coordinated care organization and the authority that is entered into, amended or renewed on or after the effective date of this 2017 Act.

SECTION 11. (1) The amendments to ORS 414.625 by section 2 of this 2017 Act become operative on January 1, 2023.

(2) The amendments to ORS 414.653 by section 9 of this 2017 Act become operative on January 1, 2024.

SECTION 12. Section 3 of this 2017 Act is repealed on December 31, 2019.

SECTION 13. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect on its passage.