# HOUSE AMENDMENTS TO A-ENGROSSED HOUSE BILL 2122

By COMMITTEE ON RULES

May 16

On page 1 of the printed A-engrossed bill, line 3, delete "and 414.627" and insert ", 414.627 and 414.653".

Delete lines 5 through 20 and delete pages 2 and 3.

On page 4, delete lines 1 through 16 and insert:

"**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.

"(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 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) 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.**".

In line 17, delete "5" and insert "6".

On page 5, line 21, delete "6" and insert "7".

On page 8, after line 39, insert:

"(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 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) 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).".

Delete lines 40 and 41 and insert:

"**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:".

On page 9, after line 1, insert:

"**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.**".

In line 2, delete "8" and insert "13".