House Bill 2122

Sponsored by Representative GREENLICK (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 **as introduced.**

Modifies requirements for coordinated care organizations in 2018 and 2023. Beginning in 2023, requires coordinated care organizations to be community-based nonprofit organizations, to have membership of governing body that reflects local control and to distribute at least 80 percent of payments to providers using alternative payment methodologies.

Creates Community Escrow Fund in State Treasury to hold coordinated care organization restricted reserves.

Requires Oregon Health Policy Board to adopt minimum criteria for continuation of contracts with coordinated care organization.

Requires coordinated care organizations seeking to contract with Oregon Health Authority in 2018 to present plan for moving toward 2023 requirements and to explain steps taken to innovate health care delivery.

A BILL FOR AN ACT

Relating to coordinated care organizations; creating new provisions; and amending ORS 414.625, 414.651 and 414.653.

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

SECTION 1. (1) The membership of the governing body of a coordinated care organization must include:

(a) Individuals or representatives of entities that share in the financial risk of the organization who may constitute no more than 25 percent of the membership;

(b) The following individuals who may constitute no more than 25 percent of the membership:

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

(B) A physician or nurse practitioner whose area of practice is primary care; and

(C) A mental health or chemical dependency treatment provider.

(c) Members from the community at large, who must constitute at least 50 percent of the membership and include the chairperson of the community advisory council.

(2) The governing body of a coordinated care organization is subject to ORS 192.610 to 192.690.

SECTION 2. (1) The Community Escrow Fund is established in the State Treasury, separate and distinct from the General Fund, consisting of moneys allocated to the Community Escrow Fund by the Oregon Health Authority in accordance with section 4 of this 2017 Act. Interest earned by the fund shall be credited to the fund. Moneys in the fund are continuously appropriated to the authority for the purposes described in section 3 of this 2017 Act.

(2) Each coordinated care organization that contracts with the authority shall have a designated subaccount within the fund.

SECTION 3. The Oregon Health Authority shall adopt by rule criteria for the amount of and eligibility for a payment of moneys from the Community Escrow Fund in order to pay

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.

costs not accounted for in establishing a coordinated care organization's global budget. A coordinated care organization seeking moneys from the fund shall make an application to the authority in a form and manner prescribed by the authority. Upon finding that the coordinated care organization meets the criteria adopted under this section, the authority shall make a payment to the coordinated care organization from the subaccount designated for the coordinated care organization.

SECTION 4. The Oregon Health Authority shall withhold an amount from each global budget payment made to a coordinated care organization. The amount withheld shall be paid into a subaccount designated for the coordinated care organization within the Community Escrow Fund established under section 2 of this 2017 Act. The amount withheld shall be calculated to achieve, by January 1, 2023, an amount equal to the restricted reserves required for the coordinated care organization under ORS 414.625 (1)(b)(A).

SECTION 5. Notwithstanding ORS 414.625 (1)(b)(A), a coordinated care organization may expend its restricted reserves for operating expenses up to the total amount withheld from the coordinated care organization by the authority under section 4 of this 2017 Act.

SECTION 6. (1) The Oregon Health Policy Board shall adopt three to five criteria that a coordinated care organization must meet in order to continue to contract with the Oregon Health Authority to provide medical assistance in this state. The criteria must be designed to ensure that a coordinated care organization is taking minimum steps necessary to achieve the goals of the Oregon Integrated and Coordinated Health Care Delivery System described in ORS 414.620 (1).

(2) The authority shall require coordinated care organizations to report data and other information to enable the authority to evaluate whether coordinated care organizations are meeting the criteria adopted by the board under subsection (1) of this section.

(3) Upon the receipt of data or other information which the authority determines shows a failure of a coordinated care organization to meet the criteria, the authority shall provide written notice to the coordinated care organization explaining its determination and the basis for its determination. The authority shall offer a coordinated care organization an action plan containing steps the coordinated care organization must take to remedy the failure within a period of 12 months.

(4) The authority shall terminate the contract of a coordinated care organization that refuses to accept the action plan described in subsection (3) of this section. If a coordinated care organization accepts the action plan but fails to comply with the action plan within 12 months after the effective date of the action plan, the authority shall terminate the contract of the organization.

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*] **must** be [*local,*] community-based **nonprofit** 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)*] **(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, 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 **meets the requirements of section 1 of this 2017 Act.** [*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.

SECTION 8. ORS 414.651 is amended to read:

414.651. (1)(a) The Oregon Health Authority shall use, to the greatest extent possible, coordinated care organizations to provide fully integrated physical health services, chemical dependency and mental health services and oral health services. This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.

(b) The authority shall execute contracts with **any** coordinated care organizations that meet the criteria adopted by the authority under ORS 414.625 **and any additional conditions specified in the request for proposals**. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(c) The authority shall establish financial reporting requirements for coordinated care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each coordinated care organization and that:

(A) Enables the authority to verify that the coordinated care organization's reserves and other financial resources are adequate to ensure against the risk of insolvency; and

(B) Includes information on the three highest executive salary and benefit packages of each coordinated care organization.

(d) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

(e) The authority shall require compliance with the provisions of paragraphs (c) and (d) of this subsection as a condition of entering into a contract with a coordinated care organization. A coordinated care organization, contractor or provider that fails to comply with paragraph (c) or (d) of this subsection may be subject to sanctions, including but not limited to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.

(f)(A) The authority shall adopt rules and procedures to ensure that if a rural health clinic provides a health service to a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care organization, the rural health clinic receives total aggregate payments from the member's coordinated care organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by

this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services provided pursuant to ORS 414.631, 414.651 and 414.688 to 414.745 may not exceed the total dollars appropriated for health services under ORS 414.631, 414.651 and 414.688 to 414.745.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.631, 414.651, 414.654 and 414.688 to 414.745 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.631, 414.651 and 414.688 to 414.745 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A coordinated care organization shall provide information to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.

(7) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

(8) Each coordinated care organization shall provide upon the request of a member or prospective member annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to members.

(9) A coordinated care organization may not limit enrollment in a geographic area based on the zip code of a member or prospective member.

SECTION 9. ORS 414.653 is amended to read:

414.653. (1) The Oregon Health Authority shall [*encourage*] **require** coordinated care organizations to use alternative payment methodologies [*that*] **to distribute at least 80 percent of the payments the organization makes to providers. The alternative payment methodologies must**:

(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*] **require** coordinated care organizations to utilize alternative payment methodologies [*that*] **to** move from a predominantly fee-for-service system to payment

methods that base reimbursement on the quality rather than the quantity of services provided.

(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 10. The Oregon Health Authority shall require a coordinated care organization that seeks to enter into or renew a contract that will be in effect between January 1, 2018, and December 31, 2022:

(1) To present a plan for achieving compliance with the requirements of section 1 of this 2017 Act and the requirements of ORS 414.625, as amended by section 7 of this 2017 Act, no later than January 1, 2023.

(2) To demonstrate that the coordinated care organization is taking significant steps to innovate its health care delivery system to achieve the goals described in ORS 414.620.

SECTION 11. Section 4 of this 2017 Act is amended to read:

Sec. 4. The Oregon Health Authority shall withhold an amount from [*each*] **a** global budget payment made to a coordinated care organization[. *The amount withheld shall be paid into a subaccount designated for the coordinated care organization within the Community Escrow Fund established under section 2 of this 2017 Act. The amount withheld shall be calculated to achieve, by January 1, 2023, an amount equal to the restricted reserves required for the coordinated care organization under ORS 414.625 (1)(b)(A).*] **as necessary to maintain in the subaccount designated for the coordi-**

nated care organization in the Community Escrow Fund established under section 2 of this 2017 Act $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities for the contract year that exceed $250,000.

SECTION 12. Sections 1 and 6 of this 2017 Act are added to and made a part of ORS 413.006 to 413.042.

SECTION 13. (1) The amendments to section 4 of this 2017 Act by section 11 of this 2017 Act become operative on January 1, 2023.

(2) Section 1 of this 2017 Act and the amendments to ORS 414.625 and 414.653 by sections 7 and 9 of this 2017 Act become operative on January 1, 2023.

SECTION 14. Sections 5 and 10 of this 2017 Act are repealed on January 2, 2023.