House Bill 3352

Sponsored by Representatives JOHNSON, BUEHLER, Senator STEINER HAYWARD; Representatives LIVELY, MCKEOWN, Senator ROBLAN

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.**

Establishes Task Force on Funding for School Behavioral Health Support. Requires task force to submit report no later than September 15, 2018. Sunsets task force on December 31, 2018.

Revises membership requirements of coordinated care organization governing bodies and prescribes additional requirements of coordinated care organizations.

Directs subcommittee of Health Plan Quality Metrics Committee to select health outcome and quality measures applicable to services provided by coordinated care organization to school districts and education service districts.

Authorizes district school board to enter into agreement with coordinated care organization to provide behavioral health support.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to school behavioral health support; creating new provisions; amending ORS 332.075, 414.625 and 414.638; and declaring an emergency.

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

SECTION 1. (1) The Task Force on Funding for School Behavioral Health Support is established.

(2) The task force consists of seven members appointed as follows:

(a) The President of the Senate shall appoint one member from among members of the Senate.

(b) The Speaker of the House of Representatives shall appoint one member from among members of the House of Representatives.

(c) The Governor shall appoint the following five members:

(A) One member who is a representative from the Department of Education;

(B) One member who is a representative from the Oregon Health Authority;

(C) One member who represents school district boards;

(D) One member who represents educators; and

(E) One member who represents behavioral health specialists.

(3) The task force shall examine:

(a) Funding opportunities that:

(A) Are available to school districts to pay for behavioral health support in elementary schools;

(B) May include federal moneys; and

(C) Do not include the State School Fund.

(b) Distributing any moneys received to pay for behavioral health support in elementary schools.

(4) A majority of the members of the task force constitutes a quorum for the transaction

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.

of business.

(5) Official action by the task force requires the approval of a majority of the members of the task force.

(6) The task force shall elect one of its members to serve as chairperson.

(7) If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective.

(8) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the members of the task force.

(9) The task force may adopt rules necessary for the operation of the task force.

(10) The task force shall submit a report in the manner provided by ORS 192.245, and may include recommendations for legislation, to the interim committees of the Legislative Assembly related to education no later than September 15, 2018.

(11) The Department of Education shall provide staff support to the task force.

(12) Members of the task force are not entitled to compensation or reimbursement for expenses and serve as volunteers on the task force.

(13) All agencies of state government, as defined in ORS 174.111, are directed to assist the task force in the performance of the task force's duties and, to the extent permitted by laws relating to confidentiality, to furnish information and advice the members of the task force consider necessary to perform their duties.

SECTION 2. Section 1 of this 2017 Act is repealed on December 31, 2018.

SECTION 3. ORS 414.625 is amended to read:

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

(a) Managing financial risk and establishing financial reserves.

(b) Meeting the following minimum financial requirements:

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

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

(c) Operating within a fixed global budget.

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

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

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

organization's community.

(2) In addition to the criteria specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, 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[.]**; and**

(F) At least one member who is a superintendent of a school district or an education service district.

(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.

(q) Each coordinated care organization cooperates with local school districts and education service districts to provide behavioral health support for elementary school students, focusing on students in schools that are considered high poverty under Title I of the federal Elementary and Secondary Education Act of 1965.

(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 4. ORS 414.638, as amended by section 10, chapter 389, Oregon Laws 2015, is amended to read:

414.638. (1) There is created in the Health Plan Quality Metrics Committee a nine-member metrics and scoring subcommittee appointed by the Director of the Oregon Health Authority. The members of the subcommittee serve two-year terms and must include:

(a) Three members at large;

(b) Three individuals with expertise in health outcomes measures; and

(c) Three representatives of coordinated care organizations.

(2)**(a)** The subcommittee shall select, from the health outcome and quality measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to services provided by coordinated care organizations. The Oregon Health Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

(b) In addition to the health outcome and quality measures selected by the subcommittee under paragraph (a) of this subsection, the subcommittee shall select health outcome and quality measures applicable to services provided by coordinated care organizations to school districts and education service districts, as prescribed by ORS 414.625 (2)(q), to reduce the number of students required to have an individualized education program related to behavioral issues, to reduce absenteeism rates due to behavioral issues and to reduce school discipline related to behavioral issues.

(3) The subcommittee shall evaluate the health outcome and quality measures annually, reporting recommendations based on its findings to the Health Plan Quality Metrics Committee, and adjust the measures to reflect:

(a) The amount of the global budget for a coordinated care organization;

(b) Changes in membership of the organization;

(c) The organization's costs for implementing outcome and quality measures; and

(d) The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.627.

(4) The authority shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the subcommittee under this section for members in each coordinated care organization and for members statewide.

SECTION 5. ORS 332.075 is amended to read:

332.075. (1) Any district school board may:

(a) Fix the days of the year and the hours of the day when schools shall be in session.

(b) Adopt textbooks and other instructional materials as provided in ORS 337.120 and 337.141 and courses of study for the use of such schools as provided in ORS 336.035.

(c) Authorize the use of the schools for purposes of training students of an approved educator preparation provider, as defined in ORS 342.120, and for such purposes may enter into contracts with the approved educator preparation provider on such terms as may be agreed upon. Such contracts as they relate to student teachers shall have the same effect and be subject to the same regulations as a contract between a licensed teacher and a district school board.

(d) Develop and operate with other school districts or community college districts secondary career and technical education programs for pupils of more than one district and fix by agreement the duration of the district's obligation to continue such activity, subject to the availability of funds therefor.

(e) Authorize the school district to be a member of and pay fees, if any, to any voluntary organization that administers interscholastic activities or that facilitates the scheduling and programming of interscholastic activities.

(f) Accept money or property donated for the use or benefit of the school district and, consistent with the laws of this state, use such money or property for the purpose for which it was donated.

(g) Enter into an approved written agreement with the governing body of a federally recognized Native American tribe in Oregon to allow the use of a mascot that represents, is associated with or is significant to the Native American tribe entering into the agreement. An agreement entered into under this paragraph must:

(A) Describe the acceptable uses of the mascot;

(B) Comply with rules adopted by the State Board of Education that:

(i) Are adopted after consultation with the federally recognized tribes in Oregon pursuant to ORS 182.164 (3); and

(ii) Prescribe the requirements for approval; and

(C) Be approved by the State Board of Education, which the board must provide if the agreement meets the requirements of this paragraph and the rules adopted under this paragraph.

(h) Enter into an agreement with a coordinated care organization, as defined in ORS 414.025, to provide behavioral health support in the schools of the school district.

(2) All contracts of the school district must be approved by the district school board before an order can be drawn for payment. If a contract is made without the authority of the district school board, the individual making such contract shall be personally liable.

(3) Notwithstanding subsection (2) of this section, a district school board may, by resolution or policy, authorize its superintendent or the superintendent's designee to enter into and approve payment on contracts for products, materials, supplies, capital outlay, equipment and services that are within appropriations made by the district school board pursuant to ORS 294.456. A district school board may not authorize its superintendent or the superintendent's designee under this subsection to enter into and approve payment on contracts that are collective bargaining agreements or service contracts that include the provision of labor performed by employees of the school district.

SECTION 6. The amendments to ORS 332.075, 414.625 and 414.638 by sections 3 to 5 of this 2017 Act become operative January 1, 2018.

SECTION 7. 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.
