SB 934-A6
(LC 1658)
5/24/17 (LHF/ps)

Requested by Senator STEINER HAYWARD

PROPOSED AMENDMENTS TO
A-ENGROSSED SENATE BILL 934

On page 1 of the printed A-engrossed bill, line 23, delete "at least 12" and insert "on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care".

In lines 24 and 25, delete the boldfaced material.

On page 3, line 45, after "spends" insert "on primary care" and delete "global budget" and insert "total expenditures on physical and mental health care, as required by ORS 414.625 (1)(c),".

On page 4, line 1, delete "on primary care".

In line 2, delete "global budget" and insert "total expenditures".

On page 5, line 21, delete "premiums" and insert "total medical expenditures".

In line 22, delete "premiums" and insert "total medical expenditures".

In line 24, delete the first comma and insert a colon and begin a new paragraph and insert "(a)".

After line 26, insert:

"(b) 'Total medical expenditures' means payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.".

On page 6, after line 42, insert:

"(11) 'Total medical expenditures' means payments to reimburse the cost of physical and mental health care provided to eligible employees or their family members, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.".

On page 7, line 34, after "total" insert "medical".

In line 38, after "total" insert "medical".

On page 8, after line 40, insert:

"(10) 'Total medical expenditures' means payments to reimburse the cost of physical and mental health care provided to eligible employees or their family members, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.".

On page 9, line 34, after "total" insert "medical".

In line 38, after "total" insert "medical".

On page 10, line 4, delete "December 31" and insert "October 1".

On page 11, delete lines 25 through 45 and delete pages 12 through 15.

On page 16, delete lines 1 through 12 and insert:

"**SECTION 14.** 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. 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 and[*, by January 1, 2023,*] spending on primary care, as defined [*in section 2, chapter 575, Oregon Laws 2015*] **by the authority by rule**, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

"(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 organ-

izations 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.

"(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 15. ORS 743.010, as amended by section 5 of this 2017 Act, is amended to read:

"743.010. (1) In addition to all other powers of the Director of the Department of Consumer and Business Services with respect thereto, the director may issue rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b):

"(a) Establishing minimum benefit standards;

"(b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance;

"(c) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies; and

"(d) Establishing requirements for carriers offering health benefit plans [*that spend less than*] **to spend at least** 12 percent of total medical expenditures on payments for primary care [*to submit with each rate filing a plan to increase spending on payments for primary care as a percentage of total medical expenditures by at least one percent each plan year*].

"(2) As used in this section:

"(a) 'Primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

"(b) 'Total medical expenditures' means payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

"SECTION 16. ORS 243.135, as amended by section 4, chapter 389, Oregon Laws 2015, and section 9 of this 2017 Act, is amended to read:

"243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

"(a) Employee choice among high quality plans;

"(b) A competitive marketplace;

"(c) Plan performance and information;

"(d) Employer flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) The improvement of employee health; and

"(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

"(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members.

"(4) Payroll deductions for costs that are not payable by the state or a

local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

"(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

"(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

"(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(8) [*By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care*] **If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year**.

"(9) No later than February 1 of each year, the board shall report to the Legislative Assembly on **any plan implemented under subsection (8) of this section and on** the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

"SECTION 17. ORS 243.866, as amended by section 5, chapter 389, Oregon Laws 2015, and section 11 of this 2017 Act, is amended to read:

"243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

"(a) Employee choice among high-quality plans;

"(b) Encouragement of a competitive marketplace;

"(c) Plan performance and information;

"(d) District and local government flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) Improvement of employee health; and

"(i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members.

"(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

"(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

"(5) In developing any benefit plan, the board may provide an option of

additional coverage for eligible employees and family members at an additional premium.

"(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

"(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.

"(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(9) [*By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care*] **If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year**.

"(10) No later than February 1 of each year, the board shall report to the Legislative Assembly on **any plan implemented under subsection (9) of this section and on** the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care.".
