

**A-Engrossed**  
**Senate Bill 134**

Ordered by the Senate April 9  
Including Senate Amendments dated April 9

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care)

**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.

Requires coordinated care organizations *[to develop standardized system of care to use when assessing individuals. Requires coordinated care organizations to annually submit information regarding standardized system of care to Oregon Health Authority.]* **to publish on website document to educate members regarding treatment options and support resources available for members who have mental illnesses or substance use disorders. Directs Oregon Health Authority to adopt rules regarding coordinated care organizations' approach to addressing behavioral health care.**

*[Declares emergency, effective on passage.]*

**Takes effect on 91st day following adjournment sine die.**

**A BILL FOR AN ACT**

1  
2 Relating to behavioral health care; creating new provisions; amending ORS 414.625 and 414.635; and  
3 prescribing an effective date.

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

5 **SECTION 1.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended  
6 to read:

7 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
8 quirements for a coordinated care organization and shall integrate the criteria and requirements  
9 into each contract with a coordinated care organization. Coordinated care organizations may be  
10 local, community-based organizations or statewide organizations with community-based participation  
11 in governance or any combination of the two. Coordinated care organizations may contract with  
12 counties or with other public or private entities to provide services to members. The authority may  
13 not contract with only one statewide organization. A coordinated care organization may be a single  
14 corporate structure or a network of providers organized through contractual relationships. The cri-  
15 teria and requirements adopted by the authority under this section must include, but are not limited  
16 to, a requirement that the coordinated care organization:

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

19 (b) Meet the following minimum financial requirements:

20 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-  
21 nated care organization's total actual or projected liabilities above \$250,000.

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

**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.

1 (C) Expend a portion of the annual net income or reserves of the coordinated care organization  
2 that exceed the financial requirements specified in this paragraph on services designed to address  
3 health disparities and the social determinants of health consistent with the coordinated care  
4 organization's community health improvement plan and transformation plan and the terms and con-  
5 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42  
6 U.S.C. 1315).

7 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-  
8 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care  
9 organization's total expenditures for physical and mental health care provided to members, except  
10 for expenditures on prescription drugs, vision care and dental care.

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

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

15 (f) Engage community members and health care providers in improving the health of the com-  
16 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that  
17 exist among the coordinated care organization's members and in the coordinated care organization's  
18 community.

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

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

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

26 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,  
27 using patient centered primary care homes, behavioral health homes or other models that support  
28 patient centered primary care and behavioral health care and individualized care plans to the extent  
29 feasible.

30 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-  
31 tering and leaving an acute care facility or a long term care setting.

32 (e) Members receive assistance in navigating the health care delivery system and in accessing  
33 community and social support services and statewide resources, including through the use of certi-  
34 fied health care interpreters and qualified health care interpreters, as those terms are defined in  
35 ORS 413.550.

36 (f) Services and supports are geographically located as close to where members reside as possi-  
37 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse  
38 communities and underserved populations.

39 (g) Each coordinated care organization uses health information technology to link services and  
40 care providers across the continuum of care to the greatest extent practicable and if financially vi-  
41 able.

42 (h) Each coordinated care organization complies with the safeguards for members described in  
43 ORS 414.635.

44 (i) Each coordinated care organization convenes a community advisory council that meets the  
45 criteria specified in ORS 414.627.

1 (j) Each coordinated care organization prioritizes working with members who have high health  
2 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those  
3 members in accessing and managing appropriate preventive, health, remedial and supportive care  
4 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-  
5 gency room visits and hospital admissions.

6 (k) Members have a choice of providers within the coordinated care organization's network and  
7 that providers participating in a coordinated care organization:

8 (A) Work together to develop best practices for care and service delivery to reduce waste and  
9 improve the health and well-being of members.

10 (B) Are educated about the integrated approach and how to access and communicate within the  
11 integrated system about a patient's treatment plan and health history.

12 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-  
13 making and communication.

14 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

15 (E) Include providers of specialty care.

16 (F) Are selected by coordinated care organizations using universal application and credentialing  
17 procedures and objective quality information and are removed if the providers fail to meet objective  
18 quality standards.

19 (G) Work together to develop best practices for culturally appropriate care and service delivery  
20 to reduce waste, reduce health disparities and improve the health and well-being of members.

21 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
22 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464  
23 and 442.466.

24 (m) Each coordinated care organization uses best practices in the management of finances,  
25 contracts, claims processing, payment functions and provider networks.

26 (n) Each coordinated care organization participates in the learning collaborative described in  
27 ORS 413.259 (3).

28 (o) Each coordinated care organization has a governing body that complies with section 2,  
29 chapter 49, Oregon Laws 2018, and that includes:

30 (A) At least one member representing persons that share in the financial risk of the organiza-  
31 tion;

32 (B) A representative of a dental care organization selected by the coordinated care organization;

33 (C) The major components of the health care delivery system;

34 (D) At least two health care providers in active practice, including:

35 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS  
36 678.375, whose area of practice is primary care; and

37 (ii) A mental health or chemical dependency treatment provider;

38 (E) At least two members from the community at large, to ensure that the organization's  
39 decision-making is consistent with the values of the members and the community; and

40 (F) At least one member of the community advisory council.

41 (p) Each coordinated care organization's governing body establishes standards for publicizing  
42 the activities of the coordinated care organization and the organization's community advisory  
43 councils, as necessary, to keep the community informed.

44 **(q) Each coordinated care organization publishes on a website maintained by or on behalf**  
45 **of the coordinated care organization, in a manner determined by the authority, a document**

1 **designed to educate members about best practices, care quality expectations, screening**  
2 **practices, treatment options and other support resources available for members who have**  
3 **mental illnesses or substance use disorders.**

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

6 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-  
7 thority shall:

8 (a) For members and potential members, optimize access to care and choice of providers;

9 (b) For providers, optimize choice in contracting with coordinated care organizations; and

10 (c) Allow more than one coordinated care organization to serve the geographic area if necessary  
11 to optimize access and choice under this subsection.

12 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
13 relationship with any dental care organization that serves members of the coordinated care organ-  
14 ization in the area where they reside.

15 **SECTION 2.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and sec-  
16 tion 4, chapter 49, Oregon Laws 2018, is amended to read:

17 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
18 quirements for a coordinated care organization and shall integrate the criteria and requirements  
19 into each contract with a coordinated care organization. Coordinated care organizations may be  
20 local, community-based organizations or statewide organizations with community-based participation  
21 in governance or any combination of the two. Coordinated care organizations may contract with  
22 counties or with other public or private entities to provide services to members. The authority may  
23 not contract with only one statewide organization. A coordinated care organization may be a single  
24 corporate structure or a network of providers organized through contractual relationships. The cri-  
25 teria and requirements adopted by the authority under this section must include, but are not limited  
26 to, a requirement that the coordinated care organization:

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

29 (b) Meet the following minimum financial requirements:

30 (A) Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordi-  
31 nated care organization's total actual or projected liabilities above \$250,000.

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

34 (C) Expend a portion of the annual net income or reserves of the coordinated care organization  
35 that exceed the financial requirements specified in this paragraph on services designed to address  
36 health disparities and the social determinants of health consistent with the coordinated care  
37 organization's community health improvement plan and transformation plan and the terms and con-  
38 ditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42  
39 U.S.C. 1315).

40 (c) Operate within a fixed global budget and spend on primary care, as defined by the authority  
41 by rule, at least 12 percent of the coordinated care organization's total expenditures for physical  
42 and mental health care provided to members, except for expenditures on prescription drugs, vision  
43 care and dental care.

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

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

3 (f) Engage community members and health care providers in improving the health of the com-  
4 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that  
5 exist among the coordinated care organization's members and in the coordinated care organization's  
6 community.

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

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

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

14 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,  
15 using patient centered primary care homes, behavioral health homes or other models that support  
16 patient centered primary care and behavioral health care and individualized care plans to the extent  
17 feasible.

18 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-  
19 tering and leaving an acute care facility or a long term care setting.

20 (e) Members receive assistance in navigating the health care delivery system and in accessing  
21 community and social support services and statewide resources, including through the use of certi-  
22 fied health care interpreters and qualified health care interpreters, as those terms are defined in  
23 ORS 413.550.

24 (f) Services and supports are geographically located as close to where members reside as possi-  
25 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse  
26 communities and underserved populations.

27 (g) Each coordinated care organization uses health information technology to link services and  
28 care providers across the continuum of care to the greatest extent practicable and if financially vi-  
29 able.

30 (h) Each coordinated care organization complies with the safeguards for members described in  
31 ORS 414.635.

32 (i) Each coordinated care organization convenes a community advisory council that meets the  
33 criteria specified in ORS 414.627.

34 (j) Each coordinated care organization prioritizes working with members who have high health  
35 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those  
36 members in accessing and managing appropriate preventive, health, remedial and supportive care  
37 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-  
38 gency room visits and hospital admissions.

39 (k) Members have a choice of providers within the coordinated care organization's network and  
40 that providers participating in a coordinated care organization:

41 (A) Work together to develop best practices for care and service delivery to reduce waste and  
42 improve the health and well-being of members.

43 (B) Are educated about the integrated approach and how to access and communicate within the  
44 integrated system about a patient's treatment plan and health history.

45 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-

1 making and communication.

2 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

3 (E) Include providers of specialty care.

4 (F) Are selected by coordinated care organizations using universal application and credentialing  
5 procedures and objective quality information and are removed if the providers fail to meet objective  
6 quality standards.

7 (G) Work together to develop best practices for culturally appropriate care and service delivery  
8 to reduce waste, reduce health disparities and improve the health and well-being of members.

9 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
10 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464  
11 and 442.466.

12 (m) Each coordinated care organization uses best practices in the management of finances,  
13 contracts, claims processing, payment functions and provider networks.

14 (n) Each coordinated care organization participates in the learning collaborative described in  
15 ORS 413.259 (3).

16 (o) Each coordinated care organization has a governing body that complies with section 2,  
17 chapter 49, Oregon Laws 2018, and that includes:

18 (A) At least one member representing persons that share in the financial risk of the organiza-  
19 tion;

20 (B) A representative of a dental care organization selected by the coordinated care organization;

21 (C) The major components of the health care delivery system;

22 (D) At least two health care providers in active practice, including:

23 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS  
24 678.375, whose area of practice is primary care; and

25 (ii) A mental health or chemical dependency treatment provider;

26 (E) At least two members from the community at large, to ensure that the organization's  
27 decision-making is consistent with the values of the members and the community; and

28 (F) At least one member of the community advisory council.

29 (p) Each coordinated care organization's governing body establishes standards for publicizing  
30 the activities of the coordinated care organization and the organization's community advisory  
31 councils, as necessary, to keep the community informed.

32 **(q) Each coordinated care organization publishes on a website maintained by or on behalf**  
33 **of the coordinated care organization, in a manner determined by the authority, a document**  
34 **designed to educate members about best practices, care quality expectations, screening**  
35 **practices, treatment options and other support resources available for members who have**  
36 **mental illnesses or substance use disorders.**

37 (3) The authority shall consider the participation of area agencies and other nonprofit agencies  
38 in the configuration of coordinated care organizations.

39 (4) In selecting one or more coordinated care organizations to serve a geographic area, the au-  
40 thority shall:

41 (a) For members and potential members, optimize access to care and choice of providers;

42 (b) For providers, optimize choice in contracting with coordinated care organizations; and

43 (c) Allow more than one coordinated care organization to serve the geographic area if necessary  
44 to optimize access and choice under this subsection.

45 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual

1 relationship with any dental care organization that serves members of the coordinated care organ-  
2 ization in the area where they reside.

3 **SECTION 3.** ORS 414.635 is amended to read:

4 414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled  
5 in coordinated care organizations that protect against underutilization of services and inappropriate  
6 denials of services. In addition to any other consumer rights and responsibilities established by law,  
7 each member:

8 (a) Must be encouraged to be an active partner in directing the member's health care and ser-  
9 vices and not a passive recipient of care.

10 (b) Must be educated about the coordinated care approach being used in the community, **in-**  
11 **cluding the approach to addressing behavioral health care, and provided with any assistance**  
12 **needed regarding** how to navigate the coordinated health care system.

13 (c) Must have access to advocates, including qualified peer wellness specialists, peer support  
14 specialists, personal health navigators, and qualified community health workers who are part of the  
15 member's care team to provide assistance that is culturally and linguistically appropriate to the  
16 member's need to access appropriate services and participate in processes affecting the member's  
17 care and services.

18 (d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery  
19 system to use wellness and prevention resources and to make healthy lifestyle choices.

20 (e) Shall be encouraged to work with the member's care team, including providers and commu-  
21 nity resources appropriate to the member's needs as a whole person.

22 (2) The authority shall establish and maintain an enrollment process for individuals who are  
23 dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the  
24 member to disenroll from a coordinated care organization that fails to promptly provide adequate  
25 services and:

26 (a) To enroll in another coordinated care organization of the member's choice; or

27 (b) If another organization is not available, to receive Medicare-covered services on a fee-for-  
28 service basis.

29 (3) Members and their providers and coordinated care organizations have the right to appeal  
30 decisions about care and services through the authority in an expedited manner and in accordance  
31 with the contested case procedures in ORS chapter 183.

32 (4) A health care entity may not unreasonably refuse to contract with an organization seeking  
33 to form a coordinated care organization if the participation of the entity is necessary for the or-  
34 ganization to qualify as a coordinated care organization.

35 (5) A health care entity may refuse to contract with a coordinated care organization if the re-  
36 imbursement established for a service provided by the entity under the contract is below the rea-  
37 sonable cost to the entity for providing the service.

38 (6) A health care entity that unreasonably refuses to contract with a coordinated care organ-  
39 ization may not receive fee-for-service reimbursement from the authority for services that are  
40 available through a coordinated care organization either directly or by contract.

41 (7)(a) The authority shall adopt by rule a process for resolving disputes involving:

42 (A) A health care entity's refusal to contract with a coordinated care organization under sub-  
43 sections (4) and (5) of this section.

44 (B) The termination, extension or renewal of a health care entity's contract with a coordinated  
45 care organization.

1 (b) The processes adopted under this subsection must include the use of an independent third  
2 party arbitrator.

3 (8) A coordinated care organization may not unreasonably refuse to contract with a licensed  
4 health care provider.

5 (9) The authority shall:

6 (a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Co-  
7 ordinated Health Care Delivery System and ensure a consistent response to complaints of violations  
8 of consumer rights or protections.

9 (b) Monitor and report on the statewide health care expenditures and recommend actions ap-  
10 propriate and necessary to contain the growth in health care costs incurred by all sectors of the  
11 system.

12 **SECTION 4. (1) The amendments to ORS 414.625 and 414.635 by sections 1 to 3 of this 2019**  
13 **Act become operative on January 1, 2020.**

14 **(2) The Oregon Health Authority may take any action before the operative date specified**  
15 **in subsection (1) of this section that is necessary to enable the authority to exercise, on and**  
16 **after the operative date specified in subsection (1) of this section, all of the duties, functions**  
17 **and powers conferred on the authority by the amendments to ORS 414.625 and 414.635 by**  
18 **sections 1 to 3 of this 2019 Act.**

19 **SECTION 5. This 2019 Act takes effect on the 91st day after the date on which the 2019**  
20 **regular session of the Eightieth Legislative Assembly adjourns sine die.**

21