80th OREGON LEGISLATIVE ASSEMBLY--2019 Regular Session

Senate Bill 721

Sponsored by Senator FREDERICK, Representative GORSEK; Representative DOHERTY

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.**

Requires coordinated care organization to reimburse cost of services provided by school-based health centers to members of coordinated care organization at rate paid to in-network providers.

Declares emergency, effective July 1, 2019.

1 **A BILL FOR AN ACT**

2 Relating to school-based health centers; amending ORS 414.625; and declaring an emergency.

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

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

6 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
7 quirements for a coordinated care organization and shall integrate the criteria and requirements
8 into each contract with a coordinated care organization. Coordinated care organizations may be
9 local, community-based organizations or statewide organizations with community-based participation
10 in governance or any combination of the two. Coordinated care organizations may contract with
11 counties or with other public or private entities to provide services to members. The authority may
12 not contract with only one statewide organization. A coordinated care organization may be a single
13 corporate structure or a network of providers organized through contractual relationships. The cri-
14 teria and requirements adopted by the authority under this section must include, but are not limited
15 to, a requirement that the coordinated care organization:

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

18 (b) Meet the following minimum financial requirements:

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

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

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

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

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.

for expenditures on prescription drugs, vision care and dental care.

(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) 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 and qualified health care interpreters, as those terms are defined in ORS 413.550.

(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, including the services described in ORS 414.766, 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 complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

(D) 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;

(E) 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

(F) 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.

(6) Each coordinated care organization shall reimburse the cost of services provided by school-based health centers to members of the coordinated care organization. The services must be reimbursed at the same rate paid to providers who have contracted with the coordinated care organization to provide health care to members of the coordinated care organization.

SECTION 2. ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and section 4, chapter 49, Oregon Laws 2018, 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:

(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 specified in 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 and spend on primary care, as defined 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) 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) 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:

1 (a) Each member of the coordinated care organization receives integrated person centered care
2 and services designed to provide choice, independence and dignity.
3 (b) Each member has a consistent and stable relationship with a care team that is responsible
4 for comprehensive care management and service delivery.
5 (c) The supportive and therapeutic needs of each member are addressed in a holistic fashion,
6 using patient centered primary care homes, behavioral health homes or other models that support
7 patient centered primary care and behavioral health care and individualized care plans to the extent
8 feasible.
9 (d) Members receive comprehensive transitional care, including appropriate follow-up, when en-
10 tering and leaving an acute care facility or a long term care setting.
11 (e) Members receive assistance in navigating the health care delivery system and in accessing
12 community and social support services and statewide resources, including through the use of certi-
13 fied health care interpreters and qualified health care interpreters, as those terms are defined in
14 ORS 413.550.
15 (f) Services and supports are geographically located as close to where members reside as possi-
16 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse
17 communities and underserved populations.
18 (g) Each coordinated care organization uses health information technology to link services and
19 care providers across the continuum of care to the greatest extent practicable and if financially vi-
20 able.
21 (h) Each coordinated care organization complies with the safeguards for members described in
22 ORS 414.635.
23 (i) Each coordinated care organization convenes a community advisory council that meets the
24 criteria specified in ORS 414.627.
25 (j) Each coordinated care organization prioritizes working with members who have high health
26 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
27 members in accessing and managing appropriate preventive, health, remedial and supportive care
28 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
29 gency room visits and hospital admissions.
30 (k) Members have a choice of providers within the coordinated care organization's network and
31 that providers participating in a coordinated care organization:
32 (A) Work together to develop best practices for care and service delivery to reduce waste and
33 improve the health and well-being of members.
34 (B) Are educated about the integrated approach and how to access and communicate within the
35 integrated system about a patient's treatment plan and health history.
36 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
37 making and communication.
38 (D) Are permitted to participate in the networks of multiple coordinated care organizations.
39 (E) Include providers of specialty care.
40 (F) Are selected by coordinated care organizations using universal application and credentialing
41 procedures and objective quality information and are removed if the providers fail to meet objective
42 quality standards.
43 (G) Work together to develop best practices for culturally appropriate care and service delivery
44 to reduce waste, reduce health disparities and improve the health and well-being of members.
45 (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 complies with section 2, chapter 49, Oregon Laws 2018, and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

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

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

(D) 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

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

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(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.

(6) Each coordinated care organization shall reimburse the cost of services provided by school-based health centers to members of the coordinated care organization. The services must be reimbursed at the same rate paid to providers who have contracted with the coordinated care organization to provide health care to members of the coordinated care organization.

SECTION 3. This 2019 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect July 1, 2019.