

SENATE AMENDMENTS TO A-ENGROSSED HOUSE BILL 2211

By COMMITTEE ON HEALTH CARE

May 16

1 On page 10 of the printed A-engrossed bill, delete lines 39 through 45.

2 Delete pages 11 through 13.

3 On page 14, delete lines 1 through 20 and insert:

4 “**SECTION 3.** ORS 414.572 is amended to read:

5 “414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-
6 quirements for a coordinated care organization and shall integrate the criteria and requirements
7 into each contract with a coordinated care organization. Coordinated care organizations may be
8 local, community-based organizations or statewide organizations with community-based participation
9 in governance or any combination of the two. Coordinated care organizations may contract with
10 counties or with other public or private entities to provide services to members. The authority may
11 not contract with only one statewide organization. A coordinated care organization may be a single
12 corporate structure or a network of providers organized through contractual relationships. The cri-
13 teria and requirements adopted by the authority under this section must include, but are not limited
14 to, a requirement that the coordinated care organization:

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

17 “(b) Meet the following minimum financial requirements:

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

20 “(B) Maintain capital or surplus of not less than \$2,500,000 and any additional amounts neces-
21 sary to ensure the solvency of the coordinated care organization, as specified by the authority by
22 rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

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 other payment mechanisms described in subsection
30 (6) of this section and spend on primary care, as defined by the authority by rule, at least 12 percent
31 of the coordinated care organization’s total expenditures for physical and mental health care pro-
32 vided to members, except for expenditures on prescription drugs, vision care and dental care.

33 “(d) Develop and implement alternative payment methodologies that are based on health care
34 quality and improved health outcomes.

35 “(e) Coordinate the delivery of physical health care, behavioral health care, oral health care and

1 covered long-term care services.

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

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

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

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

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

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

19 “(e) Members are provided:

20 “(A) Assistance in navigating the health care delivery system;

21 “(B) Assistance in accessing community and social support services and statewide resources;

22 “(C) Meaningful language access as required by federal and state law including, but not limited
23 to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United
24 States Department of Justice and the National Standards for Culturally and Linguistically Appro-
25 priate Services in Health and Health Care as issued by the United States Department of Health and
26 Human Services; and

27 “(D) Qualified health care interpreters or certified health care interpreters listed on the health
28 care interpreter registry, as those terms are defined in ORS 413.550.

29 “(f) Services and supports are geographically located as close to where members reside as pos-
30 sible and are, if available, offered in nontraditional settings that are accessible to families, diverse
31 communities and underserved populations.

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

35 “(h) Each coordinated care organization complies with the safeguards for members described in
36 ORS 414.605.

37 “(i) Each coordinated care organization convenes a community advisory council that meets the
38 criteria specified in ORS 414.575.

39 “(j) Each coordinated care organization prioritizes working with members who have high health
40 care needs, multiple chronic conditions or behavioral health conditions and involves those members
41 in accessing and managing appropriate preventive, health, remedial and supportive care and ser-
42 vices, including the services described in ORS 414.766, to reduce the use of avoidable emergency
43 room visits and hospital admissions.

44 “(k) Members have a choice of providers within the coordinated care organization’s network and
45 that providers participating in a coordinated care organization:

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

3 “(B) Are educated about the integrated approach and how to access and communicate within the
4 integrated system about a patient’s treatment plan and health history.

5 “(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
6 making and communication.

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

8 “(E) Include providers of specialty care.

9 “(F) Are selected by coordinated care organizations using universal application and credential-
10 ing procedures and objective quality information and are removed if the providers fail to meet ob-
11 jective quality standards.

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

15 “(L) Each coordinated care organization reports on outcome and quality measures adopted under
16 ORS 413.022 and participates in the health care data reporting system established in ORS 442.372
17 and 442.373.

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

20 “(n) Each coordinated care organization participates in the learning collaborative described in
21 ORS 413.259 (3).

22 “(o) Each coordinated care organization has a governing body that complies with ORS 414.584
23 and that includes:

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

26 “(B) A representative of a dental [*care organization*] **subcontractor** selected by the coordinated
27 care organization;

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

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

30 “(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS
31 678.375, whose area of practice is primary care; and

32 “(ii) A behavioral health provider;

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

35 “(F) At least two members of the community advisory council, one of whom is or was within the
36 previous six months a recipient of medical assistance and is at least 16 years of age or a parent,
37 guardian or primary caregiver of an individual who is or was within the previous six months a re-
38 cipient of medical assistance.

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

42 “(q) Each coordinated care organization publishes on a website maintained by or on behalf of
43 the coordinated care organization, in a manner determined by the authority, a document designed
44 to educate members about best practices, care quality expectations, screening practices, treatment
45 options and other support resources available for members who have mental illnesses or substance

1 use disorders.

2 “(r) Each coordinated care organization works with the Tribal Advisory Council established in
3 ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

4 “(A) Facilitate a resolution of any issues that arise between the coordinated care organization
5 and a provider of Indian health services within the area served by the coordinated care organiza-
6 tion;

7 “(B) Participate in the community health assessment and the development of the health im-
8 provement plan;

9 “(C) Communicate regularly with the Tribal Advisory Council; and

10 “(D) Be available for training by the office within the authority that is responsible for tribal
11 affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located
12 within the area served by the coordinated care organization and operated by an urban Indian or-
13 ganization pursuant to 25 U.S.C. 1651.

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

16 “(4) In selecting one or more coordinated care organizations to serve a geographic area, the
17 authority shall:

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

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

20 “(c) Allow more than one coordinated care organization to serve the geographic area if neces-
21 sary to optimize access and choice under this subsection.

22 “(5)(a) *[On or before July 1, 2014, each coordinated care organization must have a formal con-*
23 *tractual relationship with any dental care organization that serves members of the coordinated care*
24 *organization in the area where they reside.]* **The authority shall:**

25 “(A) **Adopt by rule the requirements for a dental subcontractor that contracts with a**
26 **coordinated care organization; and**

27 “(B) **Incorporate the requirements adopted under this subsection into any contract en-**
28 **tered into between the authority and a coordinated care organization under this section.**

29 “(b) **The authority may not require a dental subcontractor that contracts with a coordi-**
30 **nated care organization to produce any report or other information unless the requirement**
31 **is:**

32 “(A) **Established by state or federal statute, rule or regulation; or**

33 “(B) **Included in a contract entered into between the authority and a coordinated care**
34 **organization.**

35 “(6) In addition to global budgets, the authority may employ other payment mechanisms to re-
36 imburse coordinated care organizations for specified health services during limited periods of time
37 if:

38 “(a) Global budgets remain the primary means of reimbursing coordinated care organizations for
39 care and services provided to the coordinated care organization’s members;

40 “(b) The other payment mechanisms are consistent with the legislative intent expressed in ORS
41 414.018 and the system design described in ORS 414.570 (1); and

42 “(c) The payment mechanisms are employed only for health-related social needs services, such
43 as housing supports, nutritional assistance and climate-related assistance, approved for the demon-
44 stration project under 42 U.S.C. 1315 by the Centers for Medicare and Medicaid Services.”.