

House Bill 3107

Sponsored by Representative RESCHKE

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 that manages its own dental program to have dental clinical advisory group.

A BILL FOR AN ACT

1
2 Relating to dental programs managed by coordinated care organizations; creating new provisions;
3 and amending ORS 414.625.

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

5 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS chapter 414.**

6 **SECTION 2. (1) A coordinated care organization that manages its own dental program**
7 **must have an active and ongoing clinical advisory group consisting of no fewer than three**
8 **licensed dentists who practice within the geographic area served by the coordinated care**
9 **organization. The clinical advisory group shall provide a forum for dentists that contract**
10 **with the coordinated care organization to express concerns or suggestions and must be em-**
11 **powered to mediate issues raised by the dentists.**

12 **(2) The clinical advisory group must meet at least once every six months.**

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

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

25 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
26 financial reserves.

27 (b) Meet the following minimum financial requirements:

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

30 (B) Maintain a net worth in an amount equal to at least five percent of the average combined
31 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 (3) The authority shall consider the participation of area agencies and other nonprofit agencies
 45 in the configuration of coordinated care organizations.

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

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

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

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

7 (5)(a) On or before July 1, 2014, each coordinated care organization must have a formal con-
 8 tractual relationship with any dental care organization that serves members of the coordinated care
 9 organization in the area where they reside.

10 **(b) A coordinated care organization that manages its own dental program must have a**
 11 **clinical advisory group as required by section 2 of this 2019 Act.**

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

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

24 (a) Have demonstrated experience and a capacity for managing financial risk and establishing
 25 financial reserves.

26 (b) Meet the following minimum financial requirements:

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

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

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

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

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

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

45 (f) Engage community members and health care providers in improving the health of the com-

1 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
2 exist among the coordinated care organization's members and in the coordinated care organization's
3 community.

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

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

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

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

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

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

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

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

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

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

31 (j) Each coordinated care organization prioritizes working with members who have high health
32 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those
33 members in accessing and managing appropriate preventive, health, remedial and supportive care
34 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-
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36 (k) Members have a choice of providers within the coordinated care organization's network and
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41 integrated system about a patient's treatment plan and health history.

42 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-
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44 (D) Are permitted to participate in the networks of multiple coordinated care organizations.

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 3 quality standards.

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6 (L) Each coordinated care organization reports on outcome and quality measures adopted under
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 38 tractual relationship with any dental care organization that serves members of the coordinated care
 39 organization in the area where they reside.

40 **(b) A coordinated care organization that manages its own dental program must have a**
 41 **clinical advisory group as required by section 2 of this 2019 Act.**