Oregon Health Policy Board

AGENDA

July 12, 2011
Market Square Building
1515 SW 5th Avenue, 9th floor
8:00 am to 1:00 pm

Live web streamed at: OHPB Live Web Streaming

#	Time	Item	Presenter	Action Item
1	8:00	Welcome, call to order and roll **Action item:** Consent agenda • 6-23-11 minutes	Chair	X
2	8:05	Director's Report	Bruce Goldberg	
3	8:15	PEBB/OEBB update	Joan Kapowich	
4	8:30	Medicaid update	Judy Mohr Peterson	
5	8:45	Review of HB3650: Health System Transformation	Bruce Goldberg Mike Bonetto	
6	9:30	Board Action Plan update	Tina Edlund	
	9:45	Break		
7	10:00	HB3650 Workgroups: Selection process and timeline	Chair	
8	10:10	Work plan development for Health System Transformation **Work groups:** 1. Coordinated Care Organization (CCO) Criteria 2. Global Budget Methodology	Chair Tina Edlund Bruce Goldberg	
	11:15	Break		
9	11:30	Plan development for Health System Transformation workgroups: 3. Outcomes, Quality, and Efficiency Metrics 4. Medicare-Medicaid Integration of Care and Services **Work plan: Impact of defensive medicine**	Chair Tina Edlund Bruce Goldberg	
10	12:30	Public testimony	Chair	
11	1:00	Adjourn	Chair	

Next meeting:
August 9, 2011
1 – 4:30 pm
Location: Market Square Building

DRAFT

Oregon Health Policy Board
DRAFT Minutes
June 23, 2011
10:00-11:00 am
Via Teleconference

Item
Welcome and Call To Order Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA). **Consent Agenda:** Minutes from the May 10, 2011 meeting and the final charter of the Workforce Committee were unanimously approved.
Budget and Legislative Overview– Dr. Bruce Goldberg ➢ Dr. Goldberg gave an overview of the most recent milestones as the Legislature prepares to complete this session. ➢ To date, Oregon is the only state that has passed health insurance exchange legislation with significant bipartisan support in both houses. ➢ OHA's budget is waiting to be heard in the chambers and passed. Cuts have been made, such as 8% reduction to the Oregon State Hospital budget and 11% reduction to the Oregon Health Plan budget and a 19% reduction in OHA administrative costs. ➢ The cuts to the Oregon Health Plan budget are focused on reserving funding for primary care, which is in line with the transformation work that will be started pending passage of HB 3650.
Status and Time Line of HB 3650 and SB 99 – Bruce Goldberg and Mike Bonetto ➢ The Health System Transformation bill, HB 3650, will be in front of the full Ways & Means Committee with the -43 amendments. Barring any unforeseen changes, that will be the version of the bill voted on by the Legislature. ➢ Pending passage of HB 3650, the Board will sponsor four new short term work groups: Medicaid/Medicare Integration of Care and Services; Coordinated Care Organization (CCO) Certification Criteria; Outcomes, Quality and Efficiency Metrics; and Global Budget Methodology. ➢ These work groups will work to build consensus from communities and stakeholders and incorporate that into a work plan to present to the Legislature in February 2012. ➢ Rocky King has been appointed by the Governor as the Executive Director of the Health Insurance Exchange (HIX). The Governor can appoint him for 120 days to get the infrastructure up and running and then it will be up to the HIX board to put a permanent director in place.
Adjourn 10:50 am

<u>Next meeting:</u>
July 12, 2011
8:00 am – 1:00 pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

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Monthly Report to
Oregon Health Policy Board
July 12, 2011

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

Enrollment

- Through May, 2011, **91,111** more children have been enrolled into Healthy Kids for a total child enrollment of 361,184.
- This is 113.89% of our goal of 80,000 more children and a 33.74% increase in enrollment since June 2009 (baseline).
- 4,970 children are now enrolled in Healthy KidsConnect.
- *See the chart below for a more detailed look at Healthy Kids enrollment.*

OHP Standard

- As of May 15, 2011, enrollment in OHP Standard is now **71,366.**
- There have now been seventeen random drawings to date. The last drawing was on June 1, 2011 for 2,500 names. The next drawing will occur on July 6, 2011 for 2,500 names.

End of the 2011 Legislative session and the beginning of a new phase in health care transformation in Oregon

The 2011 Legislative session was an historic one for healthcare reform in Oregon. Two transformative bills were passed that will give Oregonians the tools to access the right care at the right time in the right place. The Oregon Health Authority now begins the process of implementing HB3650, the Health System Transformation bill and SB99, the Oregon Health Insurance Exchange bill. HB3650 will be the subject of today's Health Policy Board meeting.

House Bill 3650

The Health System Transformation bill passed on the evening of June 29, one day before Sine Die. The bill sets up a system of Coordinated Care Organizations (CCO) that will better serve communities around Oregon by coordinating all aspects of a patient's health: mental, physical, and dental. Each CCO will be given a global budget and will be held accountable to the health outcomes of the people it serves, rather than being paid on a fee-for-service basis. This legislation will transform the health delivery system for Medicaid clients and can eventually

expand into PEBB and OEBB and the private insurance sector. Much of today's meeting will spent around charting the work on four main issues:

- Coordinated Care Organization (CCO) criteria
- Global Budget Methodology
- Outcomes, Quality and Efficiency Metrics
- Medicare-Medicaid Integration of Care and Services

Senate Bill 99

On June 7, the House passed SB99, the Oregon Health Insurance Exchange. The bill calls for the implementation of a state exchange, which will serve as a market place for individual Oregonians and small businesses to compare and purchase health insurance plans. The federal Affordable Care Act mandates that an Exchange be set up in every state by 2014, and the passage of this bill ensures that Oregon will run its own exchange in a way best suited for Oregonians. During June's Oregon Health Policy Board meeting, the Governor appointed Rocky King the interim executive director of the Health Insurance Exchange board.

OHA Budget approved

For more information on the 2011-2013 budget, visit the OHA budget page.

Upcoming

Next OHPB meeting:
August 9, 2011
1:00 PM to 4:30 PM
Market Square Building

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%
11-Apr	353,526	4,732	358,258	90,329	4,462	113%
11-May	**354,070**	**4,970**	**359,040**	**91,111**	**782**	**114%**

Oregon Health Authority

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OHA Health Programs
Public Employees' Benefit Board
Oregon Educators Benefit Board

Update for Oregon Health Policy Board

July 12, 2011

Joan M. Kapowich, PEBB and OEBB Administrator

Oregon Health Authority

October 2011
OEBB Renewals

- Two more options for medical homes in addition to Kaiser (18.4%)
  - Providence Health Plan – Providence Choice offered for the first time as fully insured commercial product
  - ODS – New Community Care Plan
  - Around 50 groups have selected the new medical home options
  - Open enrollment August 15 – September 15
  - Promote medical homes and wellness programs

OEBB Plan design and other changes

- Added and revised benefits
  - Added weight management program for dependents
  - Added hearing aids for adults
  - Revised evidence-of-value design (partial knee/hip replacement) procedures added to the additional cost tier
  - Extended contracts through September 2013

OEBB Focus on Carriers

- Realign payment incentives away from per-service model
  - Hospital payments via DRG rather than percent of charges
  - Case rates, global rates and other forms of capitation payments
  - Investments in systems of care and infrastructure across the state by carriers

PEBB renewal January 2012
PEBB Potential Plan Design Adjustments

- Expand procedures on evidence-and-value-based additional-cost tier
- Lower costs for chronic-care visits

- Focus on members health engagement – under construction
  - Health risk assessment
  - Biometric assessment
  - Health improvement actions
  - Members promises to take action in exchange for a more generous benefit plan
  - PEBB will study the impact of this model on claims experience and outcomes in the future

Oregon Health Authority

OEBB and PEBB Focus with Carriers

- Realign payment incentives away from per-service model
  - Case rates
  - Global payment
  - Partial capitation

  - PEBB to Pilot

    Tele-health pilot planned with Providence, “doc in a closet” to provide access to primary care at the worksite

    PEBB is involved, OEBB to begin

    Fast Track to Health – phone triage links uncomplicated cases of back pain to treatment with a physical therapist in 48 hrs of contact – decrease physical therapy visits significantly

OHA,OEBB & PEBB Policy Work

- Working with Health Transformation Committees – benefit design, CCO criteria, metrics, contract language, etc.
- Working with MIT on a study of enrollment choices in OEBB – may help people make better choices
- Committee on SB 204 – on payment methodology for hospitals and ASC
- Working with other OHA entities and OHPR on payment reform strategies
- Working on timelines and work plans for next few years

Oregon Health Authority

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Oregon's health system transformation legislation

A Summary of OR House Bill 3650

For more information about Oregon's health system transformation, visit health.oregon.gov

Highlights

- Establishes Oregon Integrated and Coordinated Health Care Delivery System in which Coordinated Care Organizations (CCOs) are used to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care.
- CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and to reduce health disparities. CCOs will be accountable for care management and provision of integrated and coordinated health care for each organization's members, managed within a fixed global budget.
- Global budget is defined as: "a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization."

Section-by-Section

Section 1 - Legislative Intent

Section 2 – Establishment of Oregon Integrated and Coordinated Health Care Delivery System

Establishes Oregon Integrated and Coordinated Health Care Delivery System administered by the Oregon Health Authority (OHA), requiring Coordinated Care Organizations (CCOs) be accountable for care management and provision of integrated and coordinated health care, managed within global budgets. Requires that OHA seek input from underserved communities. Requires OHA to regularly report to the Oregon Health Policy Board, Governor and Legislative Assembly on progress of payment reform and delivery system change, including but not limited to achievement of benchmarks, progress toward eliminating health disparities, customer satisfaction, the use of primary care homes, and the involvement of local government in CCO governance and service delivery.

Section 3 – Adds selected bill language to ORS chapter 414

Section 4 – Coordinated Care Organizations

Describes qualification criteria for CCOs to be adopted by rule by OHA, including governance structure; that structure must include entities with financial risk in the organization, major components of health care delivery system and community representatives. Organizational options for CCOs include local, community-based organizations; statewide organization with community-based participation in governance; a single corporate structure; or a network of providers organized

through contractual relationships. CCO governance must include a majority interest of those with a financial stake in the organization, as well as major components of the delivery system, and be representative of the community at large. OHA shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.

CCOs should provide comprehensive, person-centered care that includes use of primary care homes and individualized care planning to the extent feasible, ensure members have a consistent relationship with care team and provider choice within the CCO, use health information technology (HIT) to link services and care providers across the continuum, provide services and supports as close as possible to where members reside and in nontraditional settings that are accessible to families, diverse communities and underserved populations, and report on outcome and quality measures identified by OHA. CCOs must convene community advisory councils, with majority consumer membership, that meet regularly to ensure that they health care needs of the community are being addressed. CCOs must have formal contractual relationships with any dental care organization in service area on or before July 1, 2014, must permit providers to participate in multiple CCOs, and must include providers of specialty care.

Section 5 - Alternative payment methodologies

Requires OHA to encourage CCOs to establish alternative payment methodologies that reward value and good health outcomes rather than volume and that limit increases in medical cost. CCOs shall also be encouraged to use payment structures other than fee-for-service that promote prevention, provide person-centered care and reward comprehensive care coordination. Providers and facilities may not charge, and CCOs may not reimburse for, services not covered by Medicare because they are related to health care acquired conditions.

Requires CCOs to reimburse Type A, Type B and rural critical access hospitals at cost until July 1, 2014. After July 1, 2014, OHA shall require CCOs to continue to reimburse specific hospitals at cost if the OHA determines that hospitals face sufficient financial risk. However, this section does not prohibit a CCO and a hospital from mutually agreeing to another method of reimbursement.

Section 6 – Patient Centered Primary Care Homes

Requires OHA to establish standards for the utilization of patient centered primary care homes (PCPCHs) within CCOs and requires CCOs to implement PCPCHs to the extent possible. Standards may require the use of federally-qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs. CCO must report uniform quality measures for PCPCHs to OHA.

Section 7 – Dually eligible individuals

Stipulates the inclusion of individuals who are dually eligible for Medicaid and Medicare. CCOs are responsible for providing Medicare and Medicaid-covered services to dual eligibles, with the exception of Medicaid-funded long term care services. Dual eligibles shall be permitted to enroll or remain enrolled in PACE programs and Medicare Advantage plans, until those plans are fully integrated into a CCO. Except for enrollment in CCOs, dual eligibles shall retain the rights and benefits of Medicare beneficiaries.

Section 8 – Consumer and provider protections

Replaced by Section 9 as of January 1, 2014.

Section 9 – Consumer and provider protections

Requires OHA to adopt by rule consumer and provider protections, and to monitor and enforce these protections. Protections must include receipt of timely, complete, and accurate information and access to competent advocates (including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers). Dual eligibles must be allowed to disenroll from a CCO that fails to promptly provide adequate services and to enroll in another coordinated care organization of the member's choice; or, if another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

A health care entity may not unreasonably refuse to contract with an organization seeking to form a CCO if that entity's participation is necessary for the organization to qualify as a CCO, although it may refuse if the reimbursement offered by the CCO is below reasonable cost for providing a given service. CCOs may not unreasonably refuse to contract with providers. Requires OHA to maintain a legislatively-approved process which includes the use of an independent, third-party arbitrator, for resolving disputes involving an entity's refusal to contract with a CCO.

Section 10 – Quality measures

Requires OHA to identify, in a public process, outcome and quality measures and benchmarks for the range of health services provided by CCOs. These measures must be incorporated into CCO contracts in order to hold CCOs accountable for performance and customer satisfaction and OHA must publish information about CCO performance at an aggregate level for each CCO. Measures must be consistent with existing measures used at the national and state level and the authority shall utilize available data systems for reporting.

Section 11 - Standards for new types of health care providers

Requires OHA to consult with the appropriate regulatory boards and advocacy groups regarding community health workers, personal health navigators, peer wellness specialists and other health care workers that are not presently regulated or certified by this state, and to develop: a) education and training requirements; and b) criteria for using these workers in CCOs. The criteria must be broad enough to work for a variety of CCOs, must meet CMS requirements qualify for federal financial participation; and may not require certification by the Home Care Commission.

Section 12 – Protected information

Requires OHA to ensure appropriate use of member information by CCOs. Members must have access to their own health information in accordance with 45 C.F.R. 164.524 and CCOs shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, and in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.529 and applicable federal privacy requirements but this does not prohibit the disclosure of information between CCOs, their provider networks, and DHS or OHA for the purpose of administering the laws of Oregon. The Health Information Technology

Oversight Council shall develop informational materials that CCOs can use to inform all participants in the health care workforce about the appropriate uses and limitations on disclosure of electronic health records, including need-based access and privacy mandates.

Section 13 – Legislative approval

Requires OHA to develop, using a meaningful public process: CCO qualification criteria; global budgeting process; CCO contract dispute process; a process allowing CCOs to file financial reports only once (not twice to OHA and to DCBS); and plans for contracts between CCOs and other public purchasers like PEBB, OEBB, and premium assistance programs. These plans must be presented to the Legislative Assembly no later than February 1, 2012 and OHA is required to renew contracts of prepaid managed care organizations until CCO criteria and global budgeting process are approved. Requires the authority to consult with the Department of Consumer and Business Services on financial reporting requirements designed to mitigate the risk of CCO insolvency. Requires the authority to prepare financial models/analyses that demonstrate the feasibility of a CCO being able to realize health care cost savings and present these to the Legislature along with other proposals.

Section 14 – Transitional provisions

Requires OHA to continue to contract with prepaid managed care organizations in areas of the state not covered by CCOs and stipulates that managed care organizations are subject to the applicable requirements for and rights of CCOs. Allows OHA to amend managed care organization contracts to enable them to become CCOs. Requires OHA to continue to renew contracts with prepaid managed care organizations and with residential chemical dependency treatment providers until those entities enter into a contract with a CCO, up to a deadline of July 1, 2013 (for residential chemical dependency) or July 1, 2014 (for managed care organizations). Contracts with prepaid managed care organizations must terminate no later than July 1, 2017.

Section 15 – Cooperation of OHA and DHS

The Oregon Health Authority and the Department of Human Services shall cooperate with each either and may delegate to each other any duties, functions or powers necessary to implement the Oregon Integrated and Coordinated Health Care Delivery System.

Section 16 – Health care cost containment

Requires OHA to study and develop recommendations for containing health care costs attributable to defensive medicine and overutilization of service. The study and recommendations should address: the cost of defensive medicine; the effectiveness of malpractice caps and of binding and non-binding medical panels to address claims of malpractice; provider self-referral practices including an examination of Stark laws exceptions and exemptions; and other topics. OHA must deliver those recommendations to the Legislature at the same time as CCO criteria and global budgeting process (February 2012).

Section 17 – Federal approvals

Requires OHA to apply for federal approvals and waivers as necessary, including approvals for: enrolling dual eligibles in CCOs, integrating Medicare Advantage plans into CCOs and using blended reimbursement methods to reimburse CCOs for their care; implementation of global budgets or

alternative payment methodologies; and use and reimbursement of non-traditional personnel such as community health workers.

The authority shall adopt rules and execute contracts with CCOs as soon as practicable following legislative approval of CCO qualification criteria and global budgeting process and after receipt of the necessary federal approval. The authority may provide for implementation in stages

Section 18 – Exemption from anti-trust laws

Finding that collaboration among public payers, private health carriers, third party purchasers and providers in order to identify service delivery systems and reimbursement methods that align incentives in support of integrated and coordinated health care delivery is in the best interest of the public, the Legislature declares its intent to exempt CCOs from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine. The OHA Director or designee may engage in state supervision necessary to promote state action immunity under state and federal antitrust laws.

Section 19 – Duties of OHA

Adds administration of the Oregon Integrated and Coordinated Health Care Delivery System and the implementation of policies designed to ensure a skilled, diverse workforce to OHA duties.

Section 20 – Definitions

Includes definition of alternative payment methodology, community health worker, Coordinated Care Organization, global budget, health services, patient-centered primary care home, peer wellness specialist, personal health navigator, and other terms. Establishes the Oregon Health Services Commission's prioritized list of health services as the starting point for benefits to be offered by CCOs.

Section 21 – Agreements with federal government regarding dual eligibles

Allows OHA to enter into agreements with (or receive grants from) the federal government to provide medical assistance to dual eligibles using integrated and coordinated health care services or alternative payment methodologies.

Section 22 – Payment for health services; Quality measures

Adds outcome and quality measures, as well as global payment methodologies, to the list of elements of health care and services that OHA may determine, subject to legislative funding. Stipulates that the Department of Human Services shall be responsible for determining payment for Medicaid-funded long-term care services and for contracting with long-term care providers.

Section 23 – Home Care Commission

Requires the Home Care Commission to work with culturally diverse community-based organizations to train and certify community health workers (CHWs) and personal health navigators. Clarifies that CCOs may retain the services of CHWs or personal health navigators not certified by the Home Care Commission as long as those personnel meet competency standards established by OHA (Section

11). However, the Home Care Commission shall ensure that CCOs honor the terms and conditions of employment for personnel that are referred to CCOs by the Commission.

Section 24 – Partnering with county government

Unless cause can be shown why such an agreement is not feasible, stipulates that the state shall require and approve agreements between CCOs and publicly funded providers for payment for certain services (e.g. immunizations, sexually transmitted disease testing) and shall allow CCO enrollees to receive family planning and HIV and AIDS-related services from these providers. The state shall encourage and approve agreements between the two entities for authorization and payment of other services including maternity case management, school-based health centers and others. CCOs must have a written agreement with the local mental health authority, unless cause can be shown why such an agreement is not feasible. That agreement may not limit the CCO's ability to contract with other public or private providers for mental health or chemical dependency services but must describe responsibilities of local mental health authority for service needs of CCO members.

Section 25 – Ombudsman services

Adds CCO members to the list of service recipients for whom OHA shall provide ombudsman services.

Section 26 – Contracts with CCOs

Requires OHA to use CCOs to the greatest extent possible but stipulates that the section does not affect and may not alter the delivery of Medicaid-funded long-term care services. Contracting provisions shall include: financial reporting requirements that enable OHA to verify that CCOs' financial resources are adequate to ensure against the risk of insolvency; outcome and quality data reporting requirements; and member notification and assistance requirements. CCOs that fail to comply with contractual requirements may be subject to sanctions or termination. OHA may contract with providers other than CCOs to provide services in regions not covered by a CCO or where the CCO's provider network is inadequate.

Section 27/28 – Mandatory enrollment

Persons eligible for health services, which do not include Medicaid-funded long-term care for the purposes of this section, must enroll in a CCO, with several exceptions including: non citizens; American Indian or Alaska Native beneficiaries; and other groups that OHA may exempt by rule (e.g. pregnant women in the third trimester). Mandatory enrollment does not apply to a person living in an area not served by a CCO or where the CCO's provider network is inadequate, or PACE enrollees. In any area not served by a CCO but covered by a prepaid managed care organization, a person must enroll with the managed care organization to receive any of the health services it offers.

Section 29 – Patient-centered primary care homes

OHA shall provide reimbursement for services provided in patient-centered primary care homes under the state's medical assistance program and shall require CCOs to offer patient-centered primary care homes to their members to the extent practicable.

Section 30 – Workforce data collection

Using data collected from all health care professional regulatory boards, the Office for Health Policy and Research shall create and maintain a health care workforce database to provide information to the Legislature and state agencies about the health care workforce.

Section 31 – Health Systems Fund

Allows the Health System Fund to be used for purpose of funding health services delivered by CCOs.

Section 32 – Health Systems Assessment

Conforms statute to make CCOs subject to current 1% tax on gross payments from OHA.

Sections 33 through 59 – Conforming amendments

- Section 40 – In areas not served by CCOs or prepaid managed health care services organizations, the authority may continue a fee-for-service system.
- Section 46 – Mental Health Drugs - OHA may not include mental health drugs in capitation rates or global budgets.
- Section 47 – CCOs that do not have a contract with a hospital must reimburse non-contracted hospitals for services provided to their members on a percentage of Medicare basis, with the exception of type A, B, and critical access hospitals. See also Section 71.

Sections 60 and 61 – Miscellaneous

Legislative Counsel may substitute 'coordinated care organization' for 'prepaid managed health care services organization' as necessary in ORS chapters 413 and 414 for purposes of harmonizing and clarifying state law.

Sections 62 through 65 – Operative and effective dates

OHA shall not implement sections of the bill that require federal approval for action or for federal financial participation prior to receiving that approval, and may not adopt rules establishing CCO certification criteria, a global budgeting process, or CCO financial reporting requirements until it has received legislative approval described in section 13. However, OHA may take action on or after the bill's effective date to seek federal approval, apply for federal grants, or adopt rules on other topics. Repeals elements of existing statute relating to managed care organizations on July 1, 2017 and repeals the transitional elements of the bill (Sections 13, 14, and 17) on January 1, 2014.

Sections 66 and 67

Adds $147,500 to OHA's general fund appropriation for 2011-13 and increases the agency's expenditure limit accordingly; increases the DHS appropriate for 2011-13 by $960,103 for seniors and people with disabilities.

Sections 68 through 70

These sections provide that certain sections of HB 2100 would be repealed and that elements of the current bill would be amended if HB 2100 becomes law.

Sections 71 and 72

Repeal portions of SB 101 relating to ORS 414.743 (payments to hospitals from health plans), if necessary, and amend Section 47 of the current bill to stipulate that non-contracted hospitals that provide less than 10% of all inpatient and outpatient hospital services to a CCO's enrollees shall be reimbursed by that CCO at a rate that is 2% less than the percentage of Medicare cost used by OHA in calculating base payments to the hospital. This subsection is not intended to discourage a coordinated care organization and a hospital from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to enrollees of the organization.

Section 73

Declare emergency; makes Act effective upon passage.

Enrolled
House Bill 3650

Sponsored by JOINT SPECIAL COMMITTEE ON HEALTH CARE TRANSFORMATION

CHAPTER .....

AN ACT

Relating to health; creating new provisions; amending ORS 192.493, 410.604, 411.404, 411.708, 413.032, 414.018, 414.025, 414.033, 414.065, 414.115, 414.153, 414.211, 414.229, 414.428, 414.620, 414.630, 414.706, 414.707, 414.712, 414.725, 414.728, 414.736, 414.737, 414.742, 414.743, 414.746, 414.760, 416.510, 416.530, 416.540, 416.610, 441.094, 442.464, 442.468, 655.515, 659.830, 735.615 and 743.847 and section 9, chapter 736, Oregon Laws 2003, sections 1 and 9, chapter 867, Oregon Laws 2009, and section 10, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 101); repealing ORS 414.610, 414.630, 414.640, 414.705, 414.736, 414.738, 414.739, 414.740 and 414.741 and section 8, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 101), and sections 128, 129, 131, 142 and 147, chapter ___, Oregon Laws 2011 (Enrolled House Bill 2100); appropriating money; limiting expenditures; and declaring an emergency.

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

HEALTH SYSTEM TRANSFORMATION

SECTION 1. ORS 414.018 is amended to read:

414.018. **Legislative intent.** (1) It is the intention of the Legislative Assembly to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost.

(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

[*(d) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state.*]

(d) The use of integrated and coordinated health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state.

(3) The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing the cost of care requires an integrated and coordinated health care system in which:

(a) Medical assistance recipients and individuals who are dually eligible for both Medicare and Medicaid participate.

(b) Health care services, other than Medicaid-funded long term care services, are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, improving health equity and reducing health disparities, utilizing patient centered primary care homes, evidence-based practices and health information technology to improve health and health care.

(c) High quality information is collected and used to measure health outcomes, health care quality and costs and clinical health information.

(d) Communities and regions are accountable for improving the health of their communities and regions, reducing avoidable health gaps among different cultural groups and managing health care resources.

(e) Care and services emphasize preventive services and services supporting individuals to live independently at home or in their community.

(f) Services are person centered, and provide choice, independence and dignity reflected in individual plans and provide assistance in accessing care and services.

(g) Interactions between the Oregon Health Authority and coordinated care organizations are done in a transparent and public manner.

(h) Moneys provided by the federal government for medical education are allocated to the institutions that provide the education.

(4) The Legislative Assembly further finds that there is an extreme need for a skilled, diverse workforce to meet the rapidly growing demand for community-based health care. To meet that need, this state must:

(a) Build on existing training programs; and

(b) Provide an opportunity for frontline care providers to have a voice in their workplace in order to effectively advocate for quality care.

(5) As used in subsection (3) of this section:

(a) "Community" means the groups within the geographic area served by a coordinated care organization and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the coordinated care organization's service area.

(b) "Region" means the geographical boundaries of the area served by a coordinated care organization as well as the governing body of each county that has jurisdiction over all or part of the coordinated care organization's service area.

SECTION 2. ORS 414.620 is amended to read:

414.620. **Establishment of Oregon Integrated and Coordinated Health Care Delivery System. (1)** There is established the Oregon **Integrated and Coordinated** Health Care [*Cost Containment*] **Delivery** System. The system shall consist of state policies and actions that [*encourage price competition among health care providers, that monitor services and costs of the health care system in Oregon, and that maintain the regulatory controls necessary to assure quality and affordable health services to all Oregonians. The system shall also include contracts with providers on a prepaid capitation basis for the provision of at least hospital or physician medical care, or both, to eligible persons as described in ORS 414.025.*] **make coordinated care organizations accountable for care management and provision of integrated and coordinated health care for each organization's members, managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.**

(2) The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically

isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.

(3) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:

(a) The achievement of benchmarks;

(b) Progress toward eliminating health disparities;

(c) Results of evaluations;

(d) Rules adopted;

(e) Customer satisfaction;

(f) Use of patient centered primary care homes;

(g) The involvement of local governments in governance and service delivery; and

(h) Other developments with respect to coordinated care organizations.

SECTION 3. Adding to ORS chapter 414. Sections 4 to 8, 10 to 15 and 17 of this 2011 Act are added to and made a part of ORS chapter 414.

SECTION 4. Coordinated care organizations. (1) The Oregon Health Authority shall adopt by rule the criteria for a coordinated care organization and shall integrate the criteria 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 be designed 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 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 409.615, community health workers and personal health navigators who meet competency standards established by the authority under section 11 of this 2011 Act 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.

(h) Each coordinated care organization complies with the safeguards for members described in section 8 of this 2011 Act.

(i) Each coordinated care organization convenes a community advisory council that includes representatives of the community and of county government, but with consumers

making up a majority of the membership, and that meets regularly to ensure that the health care needs of the consumers and the community are being addressed.

(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, 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 identified by the authority under section 10 of this 2011 Act 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 442.210 (3).

(o) Each coordinated care organization has a governance structure that includes:

(A) A majority interest consisting of the persons that share in the financial risk of the organization;

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

(C) The community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community.

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

(3) 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 5. Alternative payment methodologies. (1) The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that:

(a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;

(b) Hold organizations and providers responsible for the efficient delivery of quality care;

(c) Reward good performance;

(d) Limit increases in medical costs; and

(e) Use payment structures that create incentives to:

(A) Promote prevention;

(B) Provide person centered care; and

(C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes.

(2) The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

(3) The authority shall assist and support coordinated care organizations in identifying cost-cutting measures.

(4) If a service provided in a health care facility is not covered by Medicare because the service is related to a health care acquired condition, the cost of the service may not be:

(a) Charged by a health care facility or any health services provider employed by or with privileges at the facility, to a coordinated care organization, a patient or a third-party payer; or

(b) Reimbursed by a coordinated care organization.

(5)(a) Notwithstanding subsections (1) and (2) of this section, until July 1, 2014, a coordinated care organization that contracts with a Type A or Type B hospital or a rural critical access hospital, as described in ORS 442.470, shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the coordinated care organization for the contract period.

(b) The authority shall base the global payments to coordinated care organizations that contract with rural hospitals described in this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(c) The authority shall identify any rural hospital that would not be expected to remain financially viable if paid in a manner other than as prescribed in paragraphs (a) and (b) of this subsection based upon an evaluation by an actuary retained by the authority. On and after July 1, 2014, the authority may, on a case-by-case basis, require a coordinated care organization to continue to reimburse a rural hospital determined to be at financial risk, in the manner prescribed in paragraphs (a) and (b) of this subsection.

(d) This subsection does not prohibit a coordinated care organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this subsection.

(e) Hospitals reimbursed under paragraphs (a) and (b) of this subsection are not entitled to any additional reimbursement for services provided.

(6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations must comply with federal requirements for payments to providers of Indian health services, including but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

SECTION 6. Patient centered primary care homes. (1) The Oregon Health Authority shall establish standards for the utilization of patient centered primary care homes in coordinated care organizations.

(2) Each coordinated care organization shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The organization shall require its other health and services providers to communicate and coordinate care with the patient centered primary care home in a timely manner using electronic health information technology.

(3) Standards established by the authority for the utilization of patient centered primary care homes by coordinated care organizations may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.

(4) Each coordinated care organization shall report to the authority on uniform quality measures prescribed by the authority by rule for patient centered primary care homes.

(5) Patient centered primary care homes must participate in the learning collaborative described in ORS 442.210 (3).

SECTION 7. Dually eligible individuals. (1) Subject to the Oregon Health Authority obtaining any necessary authorization from the Centers for Medicare and Medicaid Services under section 17 of this 2011 Act, coordinated care organizations that meet the criteria adopted under section 4 of this 2011 Act are responsible for providing covered Medicare and Medicaid services, other than Medicaid-funded long term care services, to members who are dually eligible for Medicare and Medicaid in addition to medical assistance recipients.

(2) An individual who is dually eligible for Medicare and Medicaid shall be permitted to enroll in and remain enrolled in a:

(a) Program of all-inclusive care for the elderly, as defined in 42 C.F.R. 460.6; and

(b) A Medicare Advantage plan, as defined in 42 C.F.R. 422.2, until the plan is fully integrated into a coordinated care organization.

(3) Except for the enrollment in coordinated care organizations of individuals who are dually eligible for Medicare and Medicaid, the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act shall be preserved.

SECTION 8. Consumer and provider protections. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

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

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

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

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

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

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

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

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

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

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

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

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

(7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.

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

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.

SECTION 9. Section 8 of this 2011 Act is amended to read:

Sec. 8. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

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

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

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

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

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

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

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

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

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

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

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

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

(7) The authority shall [*develop a*] **maintain the** process**, approved by the Legislative Assembly,** for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. [*The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.*]

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

(9) The authority shall:

(a) Monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights or protections.

(b) Monitor and report on the statewide health care expenditures and recommend actions appropriate and necessary to contain the growth in health care costs incurred by all sectors of the system.

SECTION 10. Quality measures. (1) The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations. The authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements.

(2) The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.

(3) Quality measures identified by the authority under this section must be consistent with existing state and national quality measures. The authority shall utilize available data systems for reporting and take actions to eliminate any redundant reporting or reporting of limited value.

(4) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:

(a) Quality measures;

(b) Costs;

(c) Outcomes; and

(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.

SECTION 11. Standards for health care workers. (1) The Oregon Health Authority, in consultation with the appropriate health professional regulatory boards as defined in ORS 676.160 and advocacy groups, shall develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by this state:

(a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and

(b) Education and training requirements for such individuals.

(2) The criteria and requirements established under subsection (1) of this section:

(a) Must be broad enough to encompass the potential unique needs of any coordinated care organization;

(b) Must meet requirements of the Centers for Medicare and Medicaid Services to qualify for federal financial participation; and

(c) May not require certification by the Home Care Commission.

SECTION 12. Protected information. (1) The Oregon Health Authority shall ensure the appropriate use of member information by coordinated care organizations, including the use of electronic health information and administrative data that is available when and where the data is needed to improve health and health care through a secure, confidential health information exchange.

(2) A member of a coordinated care organization must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 so the member can share the information with others involved in the member's care and make better health care and lifestyle choices.

(3) Notwithstanding ORS 179.505, a coordinated care organization, its provider network and programs administered by the Department of Human Services for seniors and persons with disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members.

(4) A coordinated care organization and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the coordinated care organization for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.529 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the coordinated care organization and the organization's providers for purposes unrelated to this section or the requirements of section 4, 5, 6, 7, 8 or 10 of this 2011 Act remains subject to any applicable federal or state privacy requirements.

(5) This section does not prohibit the disclosure of information between a coordinated care organization and the organization's provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the laws of Oregon.

(6) The Health Information Technology Oversight Council shall develop readily available informational materials that can be used by coordinated care organizations and providers to inform all participants in the health care workforce about the appropriate uses and limitations on disclosure of electronic health records, including need-based access and privacy mandates.

SECTION 13. Legislative approval. (1) The speed and pace of the transition to the Oregon Integrated and Coordinated Health Care Delivery System will be determined by the availability of coordinated care organizations throughout the state.

(2) Using a meaningful public process, the Oregon Health Authority shall develop:

(a) Qualification criteria for coordinated care organizations in accordance with section 4 of this 2011 Act;

(b) A global budgeting process for determining payments to coordinated care organizations and for revising required outcomes with any changes to global budgets;

(c) A process for resolving a health care entity's refusal to contract with a coordinated care organization, as required by section 8 of this 2011 Act;

(d) A process that allows a coordinated care organization to file financial reports with only one regulatory agency and does not require a coordinated care organization to report information described in ORS 414.725 (1)(c) to both the authority and the Department of Consumer and Business Services; and

(e) Plans for contracts with coordinated care organizations for other public health benefit purchasers, including the private health option under ORS 414.826, the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

(3) The authority, in consultation with the Department of Consumer and Business Services, shall develop a proposal for the financial reporting requirements for coordinated care organizations to be implemented under ORS 414.725 (1)(c) to ensure against the organization's risk of insolvency. The proposal must include but need not be limited to recommendations on:

(a) The filing of quarterly and annual audited statements of financial position, including reserves and retrospective cash flows, and the filing of quarterly and annual statements of projected cash flows;

(b) Guidance for a plain-language narrative explanation of the financial statements required in paragraph (a) of this subsection;

(c) The filing by a coordinated care organization of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer, will guarantee the organization's ultimate financial risk;

(d) The disclosure of a coordinated care organization's holdings of real property and its 20 largest investment holdings, if any;

(e) The disclosure by category of administrative expenses related to the provision of health services under the coordinated care organization's contract with the authority;

(f) The disclosure of the three highest executive salary and benefit packages of each coordinated care organization;

(g) The process by which a coordinated care organization will be evaluated or audited for financial soundness and stability and the organization's ability to accept financial risk under its contracts, which process may include the use of employed or retained actuaries;

(h) A description of how the required statements and the final results of evaluations and audits will be made available to the public over the Internet at no cost to the public;

(i) A range of sanctions that may be imposed on a coordinated care organization deemed to be financially unsound and the process for determining sanctions; and

(j) Whether a new category of license should be created for coordinated care organizations recognizing their unique role but avoiding duplicative requirements for organizations that contract with the authority but are also licensed by the Department of Consumer and Business Services.

(4) The authority shall regularly report on the development of the plans, criteria and processes described in subsections (2) and (3) of this section to the Joint Interim Committee on Health Care Transformation or, if such committee has not been appointed, to another appropriate interim committee of the Legislative Assembly.

(5) The authority shall present the proposals developed under this section to the Legislative Assembly for approval no later than February 1, 2012.

(6) Until the coordinated care organization qualification criteria and the global budgeting process are approved by the Legislative Assembly, the authority shall renew the contracts of prepaid managed care health services organizations, as defined in ORS 414.736, to provide health services.

(7) The authority shall prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings. The authority shall present the models and analyses to the Legislative Assembly along with the proposals developed by the authority under this section.

SECTION 14. Transitional provisions. (1) Notwithstanding ORS 414.725 and 414.737, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.

(2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under sections 4, 6, 8, 10 and 12 of this

2011 Act and ORS 414.153, 414.712, 414.725, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.

(3) The authority may amend contracts that are in place on the effective date of this 2011 Act to allow prepaid managed care health services organizations that meet the criteria approved by the Legislative Assembly under section 13 of this 2011 Act to become coordinated care organizations.

(4) The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on the effective date of this 2011 Act until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.

(5) The authority shall continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a coordinated care organization but no later than July 1, 2013.

(6) Notwithstanding sections 4 (1)(g) and 6 (2) of this 2011 Act, the authority shall allow for a period of transition to the full adoption of health information technology by coordinated care organizations and patient centered primary care homes. The authority shall explore options for assisting providers and coordinated care organizations in funding their use of health information technology.

SECTION 15. Cooperation of Oregon Health Authority and Department of Human Services. (1) The Oregon Health Authority and the Department of Human Services shall cooperate with each other by coordinating actions and responsibilities necessary to implement the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620.

(2) The authority and the department may delegate to each other any duties, functions or powers that the authority or department are authorized to perform if necessary to carry out sections 4 to 8, 10 to 15 and 17 of this 2011 Act.

SECTION 16. Health care cost containment. (1) The Oregon Health Authority shall conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice. The study and recommendations should address but are not limited to:

(a) An analysis of the cost of defensive medicine within the Oregon health care delivery system and its potential budget impact, and containment and savings that would result from recommended changes.

(b) Identification of costs within the health care delivery system, including costs to taxpayers and consumers related to care and utilization rates impacted by defensive medical procedures or medical malpractice concerns.

(c) An analysis of utilization, testing, services ordered, prescribed or delivered through centers or facilities in which there is a financial interest between the provider requesting a test or service and the entity or individual providing the test or service, including an examination of Stark laws exceptions and exemptions.

(d) Establishment of criteria for evaluation and reduced utilization of services and procedures where the health of those served is not negatively impacted or necessarily improved.

(e) Identification and analysis of the benefits and impact of caps on medical liability insurance premiums as well as the benefits and potential cost saving from the extension of coverage through the Oregon Tort Claims Act to those who serve or act as agents of the state.

(f) A path for a cap on damages for those acting on behalf of the state and serving individuals who receive medical assistance or have medical coverage through other publicly funded programs.

(g) An examination of the possible clarifications and limitations on joint and several liability requirements for coordinated care organizations so that these organizations can assume the risk of their actions but are not liable for the actions of others within the coordinated care organization or its contracted services.

(h) The effectiveness of binding and nonbinding medical panels in addressing claims of medical malpractice.

(2) The authority shall coordinate with the Department of Consumer and Business Services and other appropriate agencies, including nongovernmental agencies, in order to collect and analyze the data generated by the study and to make complete recommendations to the Legislative Assembly.

(3) The authority shall secure assistance and input from stakeholder organizations in an effort to secure the best information available relevant to the impacts on administrative costs resulting from litigation, as well as to identify cost containment or cost reduction mechanisms.

(4) The authority shall focus its efforts on the medical malpractice marketplace and coverage throughout Oregon and the impact of implementing medical malpractice liability caps, in order to provide complete information to the Legislative Assembly as it studies the collective elements of health system transformation.

(5) The authority shall present the study and recommendations for addressing health care cost containment and cost reductions to the Legislative Assembly at the same time that the coordinated care organization qualification criteria and global budgeting process are presented to the Legislative Assembly for approval under section 13 of this 2011 Act.

SECTION 17. Federal approvals. (1) To promote the adoption of alternative payment methodologies and contracting with coordinated care organizations, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services or Center for Medicare and Medicaid Innovation for any approval necessary to obtain federal financial participation in the costs of activities described in sections 4 to 8, 10 to 15 and 17 of this 2011 Act. The authority may seek necessary federal approval, including but not limited to:

(a) Federal approval necessary to enroll in coordinated care organizations individuals who are dually eligible for Medicare and Medicaid, to integrate Medicare Advantage plans into coordinated care organizations and to implement the contracting procedures and blended reimbursement methods for coordinated care organizations that include members who are dually eligible for Medicare and Medicaid, as provided in sections 7 and 8 of this 2011 Act. The authority may not seek approval to alter any of the rights or benefits of Medicare beneficiaries under Title XVIII of the Social Security Act other than as necessary to implement the provisions of sections 7 and 8 of this 2011 Act.

(b) Federal approval necessary to support the transition to and implementation of global and alternative payment systems and the formation and utilization of coordinated care organizations in the medical assistance program.

(c) Federal approval necessary to permit the use and reimbursement of nontraditional personnel such as community health workers, personal health navigators and peer wellness specialists and to permit delivery of health services, supports and supplies that have not traditionally been delivered through the Medicaid program.

(2) The authority shall seek from the Office of the Inspector General in the United States Department of Health and Human Services, the following:

(a) A waiver of the provisions of, or expansion of the safe harbors to 42 U.S.C. 1320a-7b and implementing regulations or any other necessary authorization the authority determines may be necessary to permit certain shared risk and other risk sharing arrangements among coordinated care organizations and providers.

(b) A waiver of or exemption from the provisions of 42 U.S.C. 1395nn(a) to (e) and implementing regulations or other authorization the authority determines may be necessary to permit physician referrals to other providers as needed to support the transition to and implementation of global and alternative payment systems and formation of coordinated care organizations.

(3) The authority shall adopt rules and execute contracts with coordinated care organizations as soon as practicable following legislative approval of coordinated care organization qualification criteria and a global budgeting process and after receipt of the necessary federal approval. The authority may provide for implementation in stages.

SECTION 18. Exemption from antitrust laws. (1) The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, coordinated care organizations that might otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers as to the prices of specific health services.

(2) The Director of the Oregon Health Authority or the director's designee may engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws, and may inspect or request additional documentation to verify that the Oregon Integrated and Coordinated Health Care Delivery System established under ORS 414.620 is implemented in accordance with the legislative intent expressed in ORS 414.018.

(3) The Oregon Health Authority may convene groups that include, but are not limited to, health insurance companies, health care centers, hospitals, health service organizations, employers, health care providers, health care facilities, state and local governmental entities and consumers, to facilitate the development and establishment of the Oregon Integrated and Coordinated Health Care Delivery System and health care payment reforms. Any participation by such entities and individuals shall be on a voluntary basis.

(4) The authority may:

(a) Conduct a survey of the entities and individuals specified in subsection (3) of this section concerning payment and delivery reforms; and

(b) Convene meetings at a time and place that is convenient for the entities and individuals specified in subsection (3) of this section.

(5) A survey or meeting under subsection (4) of this section is not a violation of state antitrust laws and shall be considered state action for purposes of federal antitrust laws through the state action doctrine.

SECTION 19. ORS 413.032 is amended to read:

413.032. **Duties of Oregon Health Authority.** (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board;

[*(b) Develop a plan for the Oregon Health Insurance Exchange in accordance with section 17, chapter 595, Oregon Laws 2009;*]

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620;

(c) Administer the Oregon Prescription Drug Program;

(d) Administer the Family Health Insurance Assistance Program;

(e) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(f) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

(g) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

(h) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

(i) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

(j) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage; [*and*]

(k) Develop, in consultation with the Department of Consumer and Business Services and the Health Insurance Reform Advisory Committee, one or more products designed to provide more affordable options for the small group market**; and**

(L) Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

[*(c) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the authority's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.*]

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.064 or by other statutes.

SECTION 20. ORS 414.025, as amended by section 1, chapter 73, Oregon Laws 2010, is amended to read:

414.025. **Definitions.** As used in this chapter **and ORS chapter 413**, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

[*(1)*] **(2)** "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

[*(2)*] **(3)** "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for a category of aid but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years and:

(A) Is in a foster family home or licensed child-caring agency or institution and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part; or

(B) Is 18 years of age or older, is one for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A) of this paragraph immediately prior to the person's 18th birthday.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation.

(k) Is under the age of 22 years and is in a psychiatric hospital.

(L) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(m) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(n) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(o) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(p) Is an individual or member of a group who, subject to the rules of the department, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(r) Except as otherwise provided in this section, is a pregnant woman or child for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act.

(s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(t) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

(v) Is dually eligible for Medicare and Medicaid and receiving care through a coordinated care organization.

(4) "Community health worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(5) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under section 4 of this 2011 Act.

(6) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(7) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(8) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Services Commission under ORS 414.720:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

[*(3)*] **(9)** "Income" has the meaning given that term in ORS 411.704.

[*(4)*] **(10)** "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

[*(5)*] **(11)** "Medical assistance" means so much of the [*following*] medical**, mental health, preventive, supportive, palliative** and remedial care and services as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS [*413.032*] **414.065**, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of **health services and for services described in ORS 414.710.** [*medical care:*]

[*(a) Inpatient hospital services, other than services in an institution for mental diseases;*]

[*(b) Outpatient hospital services;*]

[*(c) Other laboratory and X-ray services;*]

[*(d) Skilled nursing facility services, other than services in an institution for mental diseases;*]

[*(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;*]

[*(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;*]

[*(g) Home health care services;*]

[*(h) Private duty nursing services;*]

[*(i) Clinic services;*]

[*(j) Dental services;*]

[*(k) Physical therapy and related services;*]

[*(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;*]

[*(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;*]

[*(n) Other diagnostic, screening, preventive and rehabilitative services;*]

[*(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;*]

[*(p) Any other medical care, and any other type of remedial care recognized under state law;*]

[*(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;*]

[*(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and*]

[*(s) Hospice services.*]

[*(6)*] **(12)** "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. [*"Medical assistance" includes "health services" as defined in ORS 414.705.*] "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

[*(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.*]

(13) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under section 6 of this 2011 Act and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(14) "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

(15) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(16) "Personal health navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(17) "Quality measure" means the measures and benchmarks identified by the authority in accordance with section 10 of this 2011 Act.

[*(8)*] **(18)** "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 21. ORS 414.033 is amended to read:

414.033. **Agreements with federal government regarding dually eligible individuals.** The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project [*which determines the cost of*] **for:**

(a) Providing medical assistance to [*the medically needy and evaluates*] **individuals who are dually eligible for Medicare and Medicaid using alternative payment methodologies or integrated and coordinated health care and services; or**

(b) Evaluating service delivery systems.

SECTION 22. ORS 414.065 is amended to read:

414.065. **Payments for health services; quality measures.** (1)(a) With respect to [*medical and remedial*] **health** care and services to be provided in medical assistance during any period, [*and within the limits of funds available therefor,*] the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and [*with respect to the "health services" defined in ORS 414.705,*] subject to legislative funding [*in response to the report of the Health Services Commission*] and paragraph (b) of this subsection:

(A) The types and extent of [*medical and remedial*] **health** care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards**, including outcome and quality measures,** to be observed in the provision of [*medical and remedial*] **health** care and services.

(C) The number of days of [*medical and remedial*] **health** care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges**,** [*and*] daily rates [*to which public assistance funds will be applied toward*] **and global payments for** meeting the costs of providing [*medical and remedial care and*] **health** services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the authority may require a recipient to pay toward the cost of [*medical and remedial*] **health** care or services.

(b) [*Notwithstanding ORS 414.720 (8),*] The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of [*medical and remedial*] **health** care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the authority and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of [*medical and remedial*] **health** care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the authority for medical assistance shall constitute payment in full for all [*medical and remedial*] **health** care and services for which such payments of medical assistance were made.

[*(4) Medical benefits, standards and limits established pursuant to subsection (1)(a)(A), (B) and (C) of this section for the eligible medically needy, except for persons receiving assistance under ORS 411.706, may be less than but may not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy.*]

(4) Notwithstanding subsections (1) and (2) of this section, the Department of Human Services shall be responsible for determining the payment for Medicaid-funded long term care services and for contracting with the providers of long term care services.

SECTION 23. ORS 410.604, as amended by section 8, chapter 100, Oregon Laws 2010, is amended to read:

410.604. **Home Care Commission.** (1) The Home Care Commission shall ensure the quality of home care services by:

(a) Establishing qualifications for home care workers with the advice and consent of the Department of Human Services;

(b) Providing training opportunities for home care workers and elderly persons and persons with disabilities who employ home care workers;

(c) Establishing and maintaining a registry of qualified home care workers;

(d) Providing routine, emergency and respite referrals of home care workers;

(e) Entering into contracts with public and private organizations and individuals for the purpose of obtaining or developing training materials and curriculum or other services as may be needed by the commission; and

(f) Working cooperatively with area agencies and state and local agencies to accomplish the duties listed in paragraphs (a) to (e) of this subsection.

(2)(a) The commission shall enter into an interagency agreement with the department to contract for a department employee to serve as executive director of the commission. The executive director shall be appointed by the Director of Human Services in consultation with the Governor and subject to approval by the commission, and shall serve at the pleasure of the Director of Human

Services. The commission may delegate to the executive director the authority to act on behalf of the commission to carry out its duties and responsibilities, including but not limited to:

(A) Entering into contracts or agreements; and

(B) Taking reasonable or necessary actions related to the commission's role as employer of record for home care workers under ORS 410.612.

(b) The commission shall enter into an interagency agreement with the department for carrying out any of the duties or functions of the commission, for department expenditures and for the provision of staff support by the department.

(3) When conducting its activities, and in making decisions relating to those activities, the commission shall first consider the effect of its activities and decisions on:

(a) Improving the quality of service delivered by home care workers;

(b) Ensuring adequate hours of service are provided to elderly persons and persons with disabilities by home care workers; and

(c) Ensuring that services, activities and purchases that are purchased by elderly persons and persons with disabilities other than home care services, including adult support services, are not compromised or diminished.

(4) The commission shall work with culturally diverse community-based organizations to train and certify community health workers and personal health navigators. The workers and navigators shall work as part of a multidisciplinary team under the direction of a licensed or certified health care professional. The commission shall recruit qualified home care workers who desire to be trained and certified as community health workers or personal health navigators.

(5) The commission shall ensure that each coordinated care organization honors all of the terms and conditions of employment established by the commission with respect to the community health workers and personal health navigators referred by the commission. This subsection does not require a coordinated care organization to employ or contract with community health workers and personal health navigators certified by the commission so long as the community health workers and personal health navigators employed or otherwise retained by the organization meet competency standards established by the authority under section 11 of this 2011 Act.

[*(4)*] **(6)** The commission has the authority to contract for services, lease, acquire, hold, own, encumber, insure, sell, replace, deal in and with and dispose of real and personal property in its own name.

(7) As used in this section, "community health worker," "coordinated care organization" and "personal health navigator" have the meanings given those terms in ORS 414.025.

SECTION 24. ORS 414.153 is amended to read:

414.153. **Partnering with county government.** In order to make advantageous use of the system of public health **care and** services available through county health departments and other publicly supported programs and to insure access to public health **care and** services through contract under ORS chapter 414, the state shall:

(1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between [*prepaid health plans*] **coordinated care organizations** and publicly funded providers for authorization of payment for point of contact services in the following categories:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

(2) Allow enrollees in [*prepaid health plans*] **coordinated care organizations** to receive from fee-for-service providers:

(a) Family planning services;

(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and

(c) Maternity case management if the Oregon Health Authority determines that a [*prepaid plan*] **coordinated care organization** cannot adequately provide the services;

(3) Encourage and approve agreements between [*prepaid health plans*] **coordinated care organizations** and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;

(e) Health **care and** services for children provided through schools and Head Start programs; and

(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and

[*(4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility.*]

(4) Recognize the responsibility of counties under ORS 430.620 to operate community mental health programs by requiring a written agreement between each coordinated care organization and the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority. The written agreements:

(a) May not limit the ability of coordinated care organizations to contract with other public or private providers for mental health or chemical dependency services;

(b) Must include agreed upon outcomes; and

(c) Must describe the authorization and payments necessary to maintain the mental health safety net system and to maintain the efficient and effective management of the following responsibilities of local mental health authorities, with respect to the service needs of members of the coordinated care organization:

(A) Management of children and adults at risk of entering or who are transitioning from the Oregon State Hospital or from residential care;

(B) Care coordination of residential services and supports for adults and children;

(C) Management of the mental health crisis system;

(D) Management of community-based specialized services including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children; and

(E) Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

SECTION 25. ORS 414.712 is amended to read:

414.712. **Ombudsman services.** The Oregon Health Authority shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who are determined eligible for medical assistance by the Department of Human Services according to ORS 411.706. The Oregon Health Authority shall also provide the following:

(1) Ombudsman services for [*eligible persons who receive assistance under*] **individuals who receive medical assistance under** ORS 411.706 **and for recipients who are members of coordinated care organizations**. With the concurrence of the Governor and the Oregon Health Policy Board, the Director of the Oregon Health Authority shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a [*patient's*] **recipient's** advocate whenever the [*patient*] **recipient** or a physician or other medical personnel serving the [*patient*] **recipient** is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider **or a coordinated care**

organization. [*Patients*] **Recipients** shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor and the Oregon Health Policy Board in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and access to or quality of care provided to eligible persons by health care providers **and coordinated care organizations**.

(2) Case management services in each health care provider organization **or coordinated care organization** for those [*eligible persons*] **individuals** who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of [*people*] **individuals** who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist [*patients*] **recipients** served by the organization with the coordination of the [*patient's*] **recipient's** health [*care*] services at the reasonable request of the [*patient*] **recipient** or a physician or other medical personnel serving the [*patient*] **recipient**. [*Patients*] **Recipients** shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a [*patient's*] **recipient's** medical needs require swift resolution of a dispute. **An ombudsman described in subsection (1) of this section may not act as the recipient's representative during any grievance or hearing process.**

SECTION 26. ORS 414.725 is amended to read:

414.725. **Contracts with coordinated care organizations.** [*(1)(a) Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the authority shall establish timelines for executing the contracts described in this paragraph.*]

[*(b)*] **(1)(a)** [*It is the intent of ORS 414.705 to 414.750 that the state*] **The Oregon Health Authority shall** use, to the greatest extent possible, [*prepaid managed care health services*] **coordinated care** organizations to provide **fully integrated** physical [*health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750*] **health services, chemical dependency and mental health services and oral health services**. **This section, and any contract entered into pursuant to this section, does not affect and may not alter the delivery of Medicaid-funded long term care services.**

[*(c)*] **(b)** The authority shall [*solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The authority may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.*] **execute contracts with coordinated care organizations that meet the criteria adopted by the authority under section 4 of this 2011 Act. Contracts under this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.**

[*(d)*] **(c)** The authority shall establish [*annual*] financial reporting requirements for [*prepaid managed care health services*] **coordinated care** organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each [*prepaid managed care health services*] **coordinated care** organization and that**:**

(A) Enables the authority to verify that the coordinated care organization's reserves and other financial resources are adequate to ensure against the risk of insolvency; and

(B) Includes information on the three highest executive salary and benefit packages of each [*prepaid managed care health services*] **coordinated care** organization.

(d) The authority shall hold coordinated care organizations, contractors and providers accountable for timely submission of outcome and quality data, including but not limited to data described in ORS 442.466, prescribed by the authority by rule.

(e) The authority shall require compliance with the provisions of [*paragraph (d)*] **paragraphs (c) and (d)** of this subsection as a condition of entering into a contract with a [*prepaid managed care health services*] **coordinated care** organization. **A coordinated care organization, contractor or provider that fails to comply with paragraph (c) or (d) of this subsection may be subject to sanctions, including but not limited to civil penalties, barring any new enrollment in the coordinated care organization and termination of the contract.**

(f)(A) The authority shall adopt rules and procedures to ensure that **if** a rural health clinic [*that*] provides a health service to [*an enrollee of a prepaid managed care health services*] **a member of a coordinated care organization, and the rural health clinic is not participating in the member's coordinated care** organization**, the rural health clinic** receives total aggregate payments from the **member's coordinated care** organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may [*institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical dependency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the authority may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite*] **contract with providers other than coordinated care organizations to provide integrated and coordinated health care in areas that are not served by a coordinated care organization or where the organization's provider network is inadequate. Contracts authorized by this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235**.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A [*prepaid managed care health services*] **coordinated care** organization shall provide information [*on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.*] **to a member as prescribed by the authority by rule, including but not limited to written information, within 30 days of enrollment with the coordinated care organization about available providers.**

(7) Each coordinated care organization shall work to provide assistance that is culturally and linguistically appropriate to the needs of the member to access appropriate services and participate in processes affecting the member's care and services.

[*(7)*] **(8)** Each [*prepaid managed care health services*] **coordinated care** organization shall provide upon the request of [*an enrollee*] **a member** or prospective [*enrollee*] **a member** annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to [*enrollees*] **members**.

[*(8)*] **(9)** A [*prepaid managed care health services*] **coordinated care** organization may not limit enrollment in a [*designated*] **geographic** area based on the zip code of [*an enrollee*] **a member** or prospective [*enrollee*] **member**.

SECTION 27. ORS 414.737 is amended to read:

414.737. **Mandatory enrollment in coordinated care organization; exemptions.** (1) Except as provided in subsections (2) [*and (3)*]**, (3) and (4)** of this section **and section 7 (2) of this 2011 Act**, a person who is eligible for or receiving [*physical health, dental, mental health or chemical dependency*] **health** services [*under ORS 414.705 to 414.750*] must be enrolled in [*the prepaid managed care health services organizations*] **a coordinated care organization** to receive the health services for which the person is eligible. **For purposes of this subsection, Medicaid-funded long term care services do not constitute health services.**

(2) [*Subsection (1)*] **Subsections (1) and (4)** of this section [*does*] **do** not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; [*and*]

(c) An individual described in section 7 (2) of this 2011 Act who is dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly; and

[*(c)*] **(d)** A person whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs; and

(E) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in [*a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.*] **an area that is not served by a coordinated care organization or where the organization's provider network is inadequate.**

(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.

[*(4)*] **(5)** As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe[*, band or group;*]

[*(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or*]**;**

(b) An individual who resides in an urban center and:

(A) Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups whose recognition was terminated since 1940 and those recognized now or in the future by the state in which the member resides, or who is a descendant in the first or second degree of such a member;

(B) Is an Eskimo or Aleut or other Alaskan Native; or

(C) Is determined to be an Indian under regulations promulgated by the United States Secretary of the Interior;

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose**; or**

(d) An individual who is considered by the United States Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaskan Native.

SECTION 28. ORS 414.737, as amended by section 8, chapter 751, Oregon Laws 2007, and section 331, chapter 595, Oregon Laws 2009, is amended to read:

414.737. **Mandatory enrollment in coordinated care organization; exemptions.** (1) Except as provided in subsections (2) [*and (3)*]**, (3), (4) and (5)** of this section **and section 7 (2) of this 2011 Act**, a person who is eligible for or receiving [*physical health, dental, mental health or chemical dependency*] **health** services [*under ORS 414.705 to 414.750*] must be enrolled in [*the prepaid managed care health services organizations*] **a coordinated care organization** to receive the health services for which the person is eligible. **For purposes of this subsection, Medicaid-funded long term care services do not constitute health services.**

(2) [*Subsection (1)*] **Subsections (1) and (4)** of this section [*does*] **do** not apply to:

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; [*and*]

(c) An individual described in section 7 (2) of this 2011 Act who is dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly; and

[*(c)*] **(d)** A person whom the Oregon Health Authority may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs;

(E) A person receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1); and

(F) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in [*a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.*] **an area that is not served by a coordinated care organization or where the organization's provider network is inadequate.**

(4) In any area that is not served by a coordinated care organization but is served by a prepaid managed care health services organization, a person must enroll with the prepaid managed care health services organization to receive any of the health services offered by the prepaid managed care health services organization.

[*(4)*] **(5)** As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe[*, band or group;*]

[*(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or*]**;**

(b) An individual who resides in an urban center and:

(A) Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups whose recognition was terminated since 1940 and those recognized now or in the future by the state in which the member resides, or who is a descendant in the first or second degree of such a member;

(B) Is an Eskimo or Aleut or other Alaskan Native; or

(C) Is determined to be an Indian under regulations promulgated by the United States Secretary of the Interior;

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose**; or**

(d) An individual who is considered by the United States Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaskan Native.

SECTION 29. ORS 414.760 is amended to read:

414.760. **Requirement to offer patient centered primary care home delivery model.** (1) [*As funds are available,*] The Oregon Health Authority [*may*] **shall** provide reimbursement in the state's medical assistance program for services provided by patient centered primary care homes. If practicable, efforts to align financial incentives to support patient centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 442.210 (3)[*(d)*].

(2) The authority shall require each coordinated care organization, to the extent practicable, to offer patient centered primary care homes that meet the standards established in section 6 of this 2011 Act.

[*(2)*] **(3)** The authority may reimburse patient centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.

[*(3)*] **(4)** The authority shall require patient centered primary care homes receiving these reimbursements to report on quality measures described in ORS 442.210 (1)(c).

SECTION 30. ORS 442.468 is amended to read:

442.468. **Workforce data collection.** (1) **Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources,** the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's healthcare workforce, including:

(a) Demographics, including race and ethnicity.

(b) Practice status.

(c) Education and training background.

(d) Population growth.

(e) Economic indicators.

(f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to healthcare education.

(2) The Administrator for the Office for Oregon Health Policy and Research may contract with a private or public entity to establish and maintain the database and to analyze the data. The office is not subject to the requirements of ORS chapters 279A, 279B and 279C with respect to the contract.

SECTION 31. Section 1, chapter 867, Oregon Laws 2009, as amended by section 46, chapter 828, Oregon Laws 2009, and section 2, chapter 73, Oregon Laws 2010, is amended to read:

Sec. 1. Health System Fund. (1) The Health System Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.

(2) Amounts in the Health System Fund are continuously appropriated to the Oregon Health Authority for the purpose of funding the Health Care for All Oregon Children program established in ORS 414.231, health services described in ORS [*414.705 (1)(a)*] **414.025 (8)(a)** to (j) and other health services. Moneys in the fund may also be used by the authority to:

(a) Provide grants to community health centers and safety net clinics under ORS 413.225.

(b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11, chapter 867, Oregon Laws 2009.

(c) Pay administrative costs incurred by the authority to administer the assessment in section 9, chapter 867, Oregon Laws 2009.

(d) Provide health services described in ORS [*414.705*] **414.025 (8)** to individuals described in ORS 414.025 [*(2)(f)(B)*] **(3)(f)(B)**.

(3) The authority shall develop a system for reimbursement by the authority to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to ORS 414.826.

SECTION 32. Section 9, chapter 867, Oregon Laws 2009, as amended by section 47, chapter 828, Oregon Laws 2009, is amended to read:

Sec. 9. (1) As used in this section**:** [*, "Medicaid managed care organization" means the following entities defined in or referred to in ORS 414.736:*]

[*(a) A fully capitated health plan.*]

[*(b) A physician care organization.*]

[*(c) A mental health organization.*]

(a) "Coordinated care organization" means an organization that meets the criteria adopted by the Oregon Health Authority under section 4 of this 2011 Act.

(b) "Medicaid managed care organization" means a prepaid managed care health services organization or a coordinated care organization.

(2) No later than 45 days following the end of a calendar quarter, a Medicaid managed care organization shall pay an assessment at a rate of one percent of the gross amount of [*capitation*] payments received by the Medicaid managed care organization **from the authority** during that calendar quarter for providing coverage of health services under ORS 414.705 to 414.750.

(3) The assessment shall be paid to the [*Oregon Health*] authority in a manner and form prescribed by the authority.

(4) Assessments received by the authority under this section shall be deposited in the Health System Fund established in section 1, chapter 867, Oregon Laws 2009.

(5) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a Medicaid managed care organization.

CONFORMING AMENDMENTS

SECTION 33. ORS 192.493 is amended to read:

192.493. A record of an agency of the executive department as defined in ORS 174.112 that contains the following information is a public record subject to inspection under ORS 192.420 and is not exempt from disclosure under ORS 192.501 or 192.502 except to the extent that the record discloses information about an individual's health or is proprietary to a person:

(1) The amounts determined by an independent actuary retained by the agency to cover the costs of providing each of the following health services under ORS 414.705 to 414.750 for the six months preceding the report:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Laboratory and X-ray services;

(d) Physician and other licensed practitioner services;

(e) Prescription drugs;

(f) Dental services;

(g) Vision services;

(h) Mental health services;

(i) Chemical dependency services;

(j) Durable medical equipment and supplies; and

(k) Other health services provided under a [*prepaid managed care health services*] **coordinated care organization** contract under ORS 414.725 **or a contract with a prepaid managed care health services organization**;

(2) The amounts the agency and each contractor have paid under each [*prepaid managed care health services*] **coordinated care organization** contract under ORS 414.725 **or prepaid managed care health services organization contract** for administrative costs and the provision of each of the health services described in subsection (1) of this section for the six months preceding the report;

(3) Any adjustments made to the amounts reported under this section to account for geographic or other differences in providing the health services; and

(4) The numbers of individuals served under each [*prepaid managed care health services*] **coordinated care organization** contract **or prepaid managed care health services organization contract**, listed by category of individual.

SECTION 34. ORS 411.404 is amended to read:

411.404. (1) The Department of Human Services shall determine eligibility for medical assistance according to criteria prescribed by rule, taking into account:

(a) The requirements and needs of the applicant and of the spouse and dependents of the applicant;

(b) The income, resources and maintenance available to the applicant; and

(c) The responsibility of the spouse of the applicant and, with respect to an applicant who is blind or is permanently and totally disabled or is under 21 years of age, the responsibility of the parents.

(2) Rules adopted by the department under subsection (1) of this section:

(a) Shall disregard resources for those who are eligible for medical assistance only by reason of ORS 414.025 [*(2)(s)*] **(3)(s)**, except for the resources described in ORS 414.025 [*(2)(s)*] **(3)(s)**.

(b) May disregard income and resources within the limits required or permitted by federal law, regulations or orders.

(3) The department may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule of the department inconsistent with this section is to that extent invalid.

SECTION 35. ORS 411.708 is amended to read:

411.708. (1) The amount of any assistance paid under ORS 411.706 is a claim against the property or interest in the property belonging to and a part of the estate of any deceased recipient. If the deceased recipient has no estate, the estate of the surviving spouse of the deceased recipient, if any, shall be charged for assistance granted under ORS 411.706 to the deceased recipient or the surviving spouse. There shall be no adjustment or recovery of assistance correctly paid on behalf of any deceased recipient under ORS 411.706 except after the death of the surviving spouse of the deceased recipient, if any, and only at a time when the deceased recipient has no surviving child who is under 21 years of age or who is blind or has a disability. Transfers of real or personal property by recipients of assistance without adequate consideration are voidable and may be set aside under ORS 411.620 (2).

(2) Except when there is a surviving spouse, or a surviving child who is under 21 years of age or who is blind or has a disability, the amount of any assistance paid under ORS 411.706 is a claim against the estate in any conservatorship proceedings and may be paid pursuant to ORS 125.495.

(3) A claim under this section shall exclude benefits paid to or on behalf of a beneficiary under a policy of qualified long term care insurance, as defined in ORS 414.025 [*(2)(t)*] **(3)(t)**.

(4) Nothing in this section authorizes the recovery of the amount of any assistance from the estate or surviving spouse of a recipient to the extent that the need for assistance resulted from a crime committed against the recipient.

SECTION 36. ORS 414.115 is amended to read:

414.115. (1) In lieu of providing one or more of the [*medical and remedial*] **health** care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such [*medical and remedial*] **health** care and services made available pursuant to ORS 414.065, the Oregon Health Authority shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the [*medical and remedial*] **health** care and services available under medical assistance for the benefit of the categorically needy. Notwithstanding other specific provisions, the use of available medical assistance funds to purchase [*medical or remedial*] **health** care and services may provide the following insurance or contract options:

(a) Differing services or levels of service among groups of eligibles as defined by rules of the authority; and

(b) Services and reimbursement for these services may vary among contracts and need not be uniform.

(2) The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the authority must guarantee:

(a) To provide [*medical and remedial*] **health** care and services of the type, within the extent and according to standards prescribed under ORS 414.065;

(b) To pay providers of [*medical and remedial*] **health** care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts which employ a method of accounting or payment on other than a fee-for-service basis;

(c) To provide [*medical and remedial*] **health** care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(d) To provide such statistical data, records and reports relating to the provision, administration and costs of providing [*medical and remedial*] **health** care and services to the authority as may be required by the authority for its records, reports and audits.

SECTION 37. ORS 414.211 is amended to read:

414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.

(2) The committee shall be composed of:

(a) A physician licensed under ORS chapter 677;

(b) Two members of health care consumer groups that include Medicaid recipients;

(c) Two Medicaid recipients, one of whom shall be a person with a disability;

(d) The Director of the Oregon Health Authority or designee;

(e) Health care providers;

(f) Persons associated with health care organizations, including but not limited to [*managed care plans*] **coordinated care organizations** under contract to the Medicaid program; and

(g) Members of the general public.

(3) In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.

(4) The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.

(5) Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Oregon Health Authority Fund.

SECTION 38. ORS 414.229 is amended to read:

414.229. (1) There is established in the Oregon Health Authority the Office for Oregon Health Policy and Research Advisory Committee composed of members appointed by the Governor. Members shall include:

(a) Representatives of [*managed care health services*] **coordinated care** organizations under contract with the Oregon Health Authority pursuant to ORS 414.725 and serving primarily rural areas of the state;

(b) Representatives of [*managed care health services*] **coordinated care** organizations under contract with the Oregon Health Authority pursuant to ORS 414.725 and serving primarily urban areas of the state;

(c) Representatives of medical organizations representing health care providers under contract with [*managed care health services*] **coordinated care** organizations pursuant to ORS 414.725 who serve patients in both rural and urban areas of the state; [*and*]

(d) One representative from Type A hospitals and one representative from Type B hospitals**; and**

(e) Representatives of health care organizations serving areas of this state that are not served by coordinated care organizations.

(2) Members of the advisory committee shall not be entitled to compensation or per diem.

SECTION 39. ORS 414.428 is amended to read:

414.428. (1) An individual described in ORS 414.025 [*(2)(s)*] **(3)(s)** who is eligible for or receiving medical assistance and who is an American Indian and Alaskan Native beneficiary shall receive the benefit package of health [*care*] services described in ORS 414.707 (1) if:

(a) The Oregon Health Authority receives 100 percent federal medical assistance percentage for payments made by the authority for the health [*care*] services provided as part of the benefit package described in ORS 414.707 (1); or

(b) The authority receives funding from the Indian tribes for which federal financial participation is available.

(2) As used in this section, "American Indian and Alaskan Native beneficiary" [*means:*]

[*(a) A member of a federally recognized Indian tribe, band or group;*]

[*(b) An Eskimo or Aleut or other Alaskan native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or*]

[*(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose*] **has the meaning given that term in ORS 414.737**.

SECTION 40. ORS 414.630 is amended to read:

414.630. (1) **In areas that are not served by a coordinated care organization,** the Oregon Health Authority [*shall*] **may** execute prepaid capitated health service contracts for at least hospital or physician medical care, or both, with hospital and medical organizations, health maintenance organizations and any other appropriate public or private persons.

(2) For purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.640, instrumentalities and political subdivisions of the state are authorized to enter into prepaid capitated health service contracts with the [*Oregon Health*] authority [*or the Oregon Health Policy Board*] and shall not thereby be considered to be transacting insurance.

(3) In the event that there is an insufficient number of qualified bids for **coordinated care organizations or** prepaid capitated health services contracts for hospital or physician medical care, or both, in some areas of the state, the [*Oregon Health*] authority may continue a fee for service payment system.

(4) Payments to providers may be subject to contract provisions requiring the retention of a specified percentage in an incentive fund or to other contract provisions by which adjustments to the payments are made based on utilization efficiency.

(5) Contracts described in this section are not subject to ORS chapters 279A and 279B, except that the contracts are subject to ORS 279A.235 and 279A.250 to 279A.290.

SECTION 41. ORS 414.706 is amended to read:

414.706. The Legislative Assembly shall approve and fund health services to the following persons:

(1) Persons who are categorically needy as described in ORS 414.025 [*(2)(o)*] **(3)(o)** and (p);

(2) Pregnant women with incomes no more than 185 percent of the federal poverty guidelines;

(3) Persons under 19 years of age with incomes no more than 200 percent of the federal poverty guidelines;

(4) Persons described in ORS 414.708; and

(5) Persons 19 years of age or older with incomes no more than 100 percent of the federal poverty guidelines who do not have federal Medicare coverage.

SECTION 42. ORS 414.707 is amended to read:

414.707. (1) Persons described in ORS 414.706 (1), (2), (3) and (5) are eligible to receive all the health services approved and funded by the Legislative Assembly.

(2) Persons described in ORS 414.708 are eligible to receive the health services described in ORS [*414.705 (1)(c)*] **414.025 (8)(c)**, (f) and (g).

SECTION 43. ORS 414.728 is amended to read:

414.728. For services provided **on a fee-for-service basis** to persons who are entitled to receive medical assistance [*and whose medical assistance benefits are not administered by a prepaid managed care health services organization, as defined in ORS 414.736*], the Oregon Health Authority shall reimburse Type A and Type B hospitals and rural critical access hospitals, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals, fully for the cost of covered services based on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

NOTE: Section 44 was deleted by amendment. Subsequent sections were not renumbered.

SECTION 45. ORS 414.736, as amended by section 6, chapter 886, Oregon Laws 2009, and section 4, chapter 417, Oregon Laws 2011 (Enrolled Senate Bill 201), is amended to read:

414.736. As used in **ORS 192.493,** this chapter, ORS chapter 416 and section 9, chapter 867, Oregon Laws 2009:

(1) "Designated area" means a geographic area of the state defined by the Oregon Health Authority by rule that is served by a prepaid managed care health services organization.

(2) "Fully capitated health plan" means an organization that contracts with the [*Oregon Health*] authority on a prepaid capitated basis under ORS [*414.725*] **414.630**.

(3) "Physician care organization" means an organization that contracts with the [*Oregon Health*] authority on a prepaid capitated basis under ORS [*414.725*] **414.630** to provide the health services described in ORS [*414.705 (1)(b)*] **414.025 (8)(b)**, (c), (d), (e), **(f),** (g) and (j). A physician care organization may also contract with the authority on a prepaid capitated basis to provide the health services described in ORS [*414.705 (1)(k)*] **414.025 (8)(k)** and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the authority on a prepaid capitated basis under ORS [*414.725*] **414.630**. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

SECTION 46. ORS 414.742 is amended to read:

414.742. The Oregon Health Authority may not establish capitation rates **or global budgets** that include payment for mental health drugs. The authority shall reimburse pharmacy providers for mental health drugs only on a fee-for-service payment basis.

SECTION 47. ORS 414.743 is amended to read:

414.743. (1) A [*fully capitated health plan*] **coordinated care organization** that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must, using a Medicare payment methodology, reimburse the noncontracting hospital for services provided to an enrollee of the plan at a rate no less than a percentage of the Medicare reimbursement rate for those services. The percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under this subsection is equal to two percentage points less than the percentage of Medicare cost used by the authority in calculating the base hospital capitation payment to the plan, excluding any supplemental payments.

(2) A hospital that does not have a contract with a [*fully capitated health plan*] **coordinated care organization** to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services the rates described in subsection (1) of this section.

(3) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(4) The Oregon Health Authority shall adopt rules to implement and administer this section.

SECTION 48. ORS 414.746 is amended to read:

414.746. (1) The Oregon Health Authority shall establish an adjustment to the [*capitation rate paid to a Medicaid managed*] **payments made to a coordinated** care organization defined in section 9, chapter 867, Oregon Laws 2009.

(2) The contracts entered into between the authority and [*Medicaid managed*] **coordinated** care organizations must include provisions that ensure that the adjustment to the [*capitation rate*] **payments** established under subsection (1) of this section is distributed by the [*Medicaid managed*] **coordinated** care organizations to hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups.

(3) The adjustment to the capitation rate paid to [*Medicaid managed*] **coordinated** care organizations shall be established in an amount consistent with the legislatively adopted budget and the aggregate assessment imposed pursuant to section 2, chapter 736, Oregon Laws 2003.

SECTION 49. ORS 416.510 is amended to read:

416.510. As used in ORS 416.510 to 416.610, unless the context requires otherwise:

(1) "Action" means an action, suit or proceeding.

(2) "Alternative payment methodology" has the meaning given that term in ORS 414.025.

[*(2)*] **(3)** "Applicant" means an applicant for assistance.

[*(3)*] **(4)** "Assistance" means moneys paid by the Department of Human Services to persons directly and moneys paid by the Oregon Health Authority or by a prepaid managed care health services organization **or a coordinated care organization** for services provided under contract pursuant to ORS 414.725 to others for the benefit of such persons.

[*(4)*] **(5)** "Authority" means the Oregon Health Authority.

[*(5)*] **(6)** "Claim" means a claim of a recipient of assistance for damages for personal injuries against any person or public body, agency or commission other than the State Accident Insurance Fund Corporation or Workers' Compensation Board.

[*(6)*] **(7)** "Compromise" means a compromise between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

(8) "Coordinated care organization" means an organization that meets the criteria adopted by the authority under section 4 of this 2011 Act.

[*(7)*] **(9)** "Judgment" means a judgment in any action or proceeding brought by a recipient to enforce the claim of the recipient.

[*(8)*] **(10)** "Prepaid managed care health services organization" means a managed health, dental or mental health care organization that [*contracts*] **contracted** with the authority on a prepaid capitated basis [*pursuant to ORS 414.725*]. Prepaid managed care health services organizations may be dental care organizations, fully capitated health plans, mental health organizations or chemical dependency organizations.

[*(9)*] **(11)** "Recipient" means a recipient of assistance.

[*(10)*] **(12)** "Settlement" means a settlement between a recipient and any person or public body, agency or commission against whom the recipient has a claim.

SECTION 50. ORS 416.530 is amended to read:

416.530. (1) If any applicant or recipient makes a claim or, without making a claim, begins an action to enforce such claim, the applicant or recipient, or the attorney for the applicant or the recipient, shall immediately notify the Department of Human Services or the Oregon Health Authority and the recipient's [*prepaid managed care health services*] **coordinated care** organization, if the recipient is receiving services from the organization. If an applicant or recipient, or the attorney

for the applicant or the recipient, has given notice that the applicant or recipient has made a claim, it shall not be necessary for the applicant or recipient, or the attorney for the applicant or the recipient, to give notice that the applicant or recipient has begun an action to enforce such claim. The notification shall include the name and address of each person or public body, agency or commission against whom claim is made or action is brought. If claim is made or action is brought against a corporation, the address given in such notification shall be that of its principal place of business. If the applicant or recipient is a minor, the parents, legal guardian or foster parents of the minor shall give the notification required by this section.

(2) The notification required by subsection (1) of this section shall be provided to:

(a) The Oregon Health Authority by applicants for or recipients of assistance provided by the authority; and

(b) The Department of Human Services for assistance provided by the department.

SECTION 51. ORS 416.540 is amended to read:

416.540. (1) Except as provided in subsection (2) of this section and in ORS 416.590, the Department of Human Services and the Oregon Health Authority shall have a lien upon the amount of any judgment in favor of a recipient or amount payable to the recipient under a settlement or compromise for all assistance received by such recipient from the date of the injury of the recipient to the date of satisfaction of such judgment or payment under such settlement or compromise.

(2) The lien does not attach to the amount of any judgment, settlement or compromise to the extent of attorney's fees, costs and expenses incurred by a recipient in securing such judgment, settlement or compromise and to the extent of medical, surgical and hospital expenses incurred by the recipient on account of the personal injuries for which the recipient had a claim.

(3) The authority may assign the lien described in subsection (1) of this section to a prepaid managed care health services organization **or a coordinated care organization** for medical costs incurred by a recipient:

(a) During a period for which the authority paid a capitation or enrollment fee **or a payment using an alternative payment methodology**; and

(b) On account of the personal injury for which the recipient had a claim.

(4) A prepaid managed care health services organization **or a coordinated care organization** to which the authority has assigned a lien shall notify the authority no later than 10 days after filing notice of a lien.

(5) For the purposes of ORS 416.510 to 416.610, the authority may designate the prepaid managed care health services organization **or the coordinated care organization** to which a lien is assigned as its designee.

(6) If the authority and a prepaid managed care health services organization **or a coordinated care organization** both have filed a lien, the authority's lien shall be satisfied first.

SECTION 52. ORS 416.610 is amended to read:

416.610. The Oregon Health Authority or the recipient's [*prepaid managed care health services*] **coordinated care** organization, if the recipient is receiving services from the organization, shall have a cause of action against any recipient who fails to give the notification required by ORS 416.530 for amounts received by the recipient pursuant to a judgment, settlement or compromise to the extent that the department or the authority or the [*prepaid managed care health services*] **coordinated care** organization could have had a lien against such amounts had such notice been given.

SECTION 53. ORS 441.094 is amended to read:

441.094. (1) No officer or employee of a hospital licensed by the Oregon Health Authority that has an emergency department may deny to a person an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available to the emergency department, to determine whether a need for emergency medical services exists.

(2) No officer or employee of a hospital licensed by the authority may deny to a person diagnosed by an admitting physician as being in need of emergency medical services the emergency

medical services customarily provided at the hospital because the person is unable to establish the ability to pay for the services.

(3) Nothing in this section is intended to relieve a person of the obligation to pay for services provided by a hospital.

(4) A hospital that does not have physician services available at the time of the emergency shall not be in violation of this section if, after a reasonable good faith effort, a physician is unable to provide or delegate the provision of emergency medical services.

(5) All [*prepaid capitated health service*] **coordinated care organization** contracts executed by the authority and private health maintenance organizations and managed care organizations shall include a provision that encourages [*a managed care plan*] **the organization** to establish agreements with hospitals in the [*plan's*] **organization's** service area for payment of emergency screening examinations.

(6) As used in subsections (1) and (2) of this section, "emergency medical services" means medical services that are usually and customarily available at the respective hospital and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or to provide care of a woman in her labor where delivery is imminent if the hospital is so equipped and, if the hospital is not equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

SECTION 54. ORS 442.464 is amended to read:

442.464. As used in this section and ORS 442.466, "reporting entity" means:

(1) An insurer as defined in ORS 731.106 or fraternal benefit society as described in ORS 748.106 required to have a certificate of authority to transact health insurance business in this state.

(2) A health care service contractor as defined in ORS 750.005 that issues medical insurance in this state.

(3) A third party administrator required to obtain a license under ORS 744.702.

(4) A pharmacy benefit manager or fiscal intermediary, or other person that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(5) A [*prepaid managed care health services organization as defined in ORS 414.736*] **coordinated care organization as defined in ORS 414.025**.

(6) An insurer providing coverage funded under Part A, Part B or Part D of Title XVIII of the Social Security Act, subject to approval by the United States Department of Health and Human Services.

SECTION 55. ORS 655.515 is amended to read:

655.515. If an inmate sustains an injury as described in ORS 655.510, benefits shall be delivered in a manner similar to that provided for injured workers under the workers' compensation laws of this state, except that:

(1) No benefits, except medical services and any occupational training or rehabilitation services provided by the Department of Corrections, shall accrue to the inmate until the date of release from confinement and shall be based upon the condition of the inmate at that time.

(2) Benefits shall be discontinued during any subsequent period of reconfinement in a penal institution.

(3) Costs of rehabilitation services to inmates with disabilities shall be paid out of the Insurance Fund established under ORS 278.425 in an amount approved by the Oregon Department of Administrative Services, which shall be the reasonable and necessary cost of such services.

(4) Medical services when the inmate is confined in a Department of Corrections facility shall be those provided by the Department of Corrections. After release, medical services shall be paid only if necessary to the process of recovery and as prescribed by the attending practitioner. No medical services may be paid after the attending practitioner has determined that the inmate is medically stationary other than for reasonable, periodic repair or replacement of prosthetic appliances. The department, by rule, may require that medical and rehabilitation services after release must be provided directly by the state or its contracted [*managed*] **coordinated** care organization.

SECTION 56. ORS 659.830 is amended to read:

659.830. (1) An employee benefit plan may not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan because that individual is provided, or is eligible for, benefits or services pursuant to a plan under Title XIX of the Social Security Act. This section applies to employee benefit plans, whether sponsored by an employer or a labor union.

(2) A group health plan is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. 1396a (section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is, by statute, contract or agreement legally responsible for payment of a claim for a health care item or service, may not deny a claim submitted by the state Medicaid agency under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency to enforce its rights with respect to the claim is commenced within six years of the agency's submission of the claim.

(5) An employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is, by statute, contract or agreement legally responsible for payment of a claim for a health care item or service, must provide to the state Medicaid agency or [*prepaid managed care health services*] **coordinated care** organization described in ORS 414.725, upon the request of the agency or contractor, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan or organization;

(b) The nature of coverage that is or was provided by the plan or organization; and

(c) The name, address and identifying numbers of the plan or organization.

(6) A group health plan may not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the group health plan service area.

(7) Where a child has health coverage through a group health plan of a noncustodial parent, the group health plan must:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, to the provider or, if a claim is filed by the state Medicaid agency, directly to the state Medicaid agency.

(8) Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the group health plan is required:

(a) To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not to disenroll or eliminate coverage of the child unless the group health plan is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(9) A group health plan may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the plan if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(10)(a) In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, the plan must provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(b) A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(11) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(b) "Group health plan" means a group health plan as defined in 29 U.S.C. 1167.

(c) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

SECTION 57. ORS 735.615, as amended by section 20, chapter 70, Oregon Laws 2011 (Enrolled Senate Bill 104), is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, a person who is a resident of this state, as defined by the Oregon Medical Insurance Pool Board, is eligible for medical pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made within a time frame established by the board an adverse underwriting decision, as defined in ORS 746.600 (1)(a)(A), (B) or (D), on individual medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section;

(c) The person is a spouse or dependent of a person described in paragraph (a) or (b) of this subsection; or

(d) The person is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for individual medical insurance pursuant to this section.

(3) A person is not eligible for coverage under ORS 735.600 to 735.650 if:

(a) Except as provided in ORS 735.625 (3) and subsection (5) of this section, the person is eligible for Medicare;

(b) The person is eligible to receive health services as defined in ORS [*414.705*] **414.025** that meet or exceed those adopted by the board;

(c) The person has terminated coverage in the pool within the last 12 months and the termination was for:

(A) A reason other than becoming eligible to receive health services as defined in ORS [*414.705*] **414.025**; or

(B) A reason that does not meet exception criteria established by the board;

(d) The person has exceeded the maximum lifetime benefit established by the board;

(e) The person is an inmate of or a patient in a public institution named in ORS 179.321;

(f) The person has, on the date of issue of coverage by the board, coverage under health insurance or a self-insurance arrangement that is substantially equivalent to coverage under ORS 735.625; or

(g) The person has the premiums paid or reimbursed by a public entity or a health care provider, reducing the financial loss or obligation of the payer.

(4) A person applying for coverage shall establish initial eligibility by providing evidence that the board requires.

(5)(a) Notwithstanding ORS 735.625 (4)(c), if a person:

(A) Becomes eligible for Medicare after being enrolled in the pool for a period of time as determined by the board by rule, that person may continue coverage within the pool as secondary coverage to Medicare.

(B) Is eligible for Medicare but is not yet eligible to enroll in Medicare Parts B and D, the individual may receive coverage under the pool until enrolled in Medicare Parts B and D.

(b) The board may adopt rules concerning the terms and conditions for the coverage provided under paragraph (a) of this subsection.

(6) The board may adopt rules to establish additional eligibility requirements for a person described in subsection [*(1)(e)*] **(1)(d)** of this section.

SECTION 58. ORS 743.847 is amended to read:

743.847. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer may not deny a claim submitted by the state Medicaid agency, [*or*] a prepaid managed care health services **organization or a coordinated care** organization described in ORS 414.725[,] under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency**,** [*or*] the prepaid managed care health services organization **or the coordinated care organization** within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency**,** [*or*] the prepaid managed care health services organization **or the coordinated care organization** to enforce its rights with respect to the claim is commenced within six years of the agency's or organization's submission of the claim.

(5) An insurer must provide to the state Medicaid agency**,** [*or*] a prepaid managed care health services organization **or a coordinated care organization**, upon request, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

(6) An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the state Medicaid agency**,** [*or*] a prepaid managed [*health*] care **health** services organization **or a coordinated care organization**, directly to the agency or the organization.

(8) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer must:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(9) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(10) The provisions of ORS 743A.001 do not apply to this section.

SECTION 59. Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, section 2, chapter 780, Oregon Laws 2007, section 53, chapter 828, Oregon Laws 2009, and section 19, chapter 867, Oregon Laws 2009, is amended to read:

Sec. 9. (1) The Hospital Quality Assurance Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Hospital Quality Assurance Fund shall be credited to the Hospital Quality Assurance Fund.

(2) Amounts in the Hospital Quality Assurance Fund are continuously appropriated to the Oregon Health Authority for the purpose of paying refunds due under section 6, chapter 736, Oregon Laws 2003, and funding services under ORS 414.705 to 414.750, including but not limited to:

(a) Increasing reimbursement rates for inpatient and outpatient hospital services under ORS 414.705 to 414.750;

(b) Maintaining, expanding or modifying services for persons described in ORS 414.025 [*(2)(s)*] **(3)(s)**;

(c) Maintaining or increasing the number of persons described in ORS 414.025 [*(2)(s)*] **(3)(s)** who are enrolled in the medical assistance program; and

(d) Paying administrative costs incurred by the authority to administer the assessments imposed under section 2, chapter 736, Oregon Laws 2003.

(3) Except for assessments imposed pursuant to section 2 (3)(b), chapter 736, Oregon Laws 2003, the authority may not use moneys from the Hospital Quality Assurance Fund to supplant, directly or indirectly, other moneys made available to fund services described in subsection (2) of this section.

MISCELLANEOUS

SECTION 60. For the purpose of harmonizing and clarifying statutory law, the Legislative Counsel may substitute for words designating a "prepaid managed care health services organization" wherever they occur in ORS chapters 413 and 414, other words designating a "coordinated care organization."

SECTION 61. The unit and section captions used in this 2011 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2011 Act.

REPEALS; APPROPRIATIONS; OPERATIVE AND EFFECTIVE DATES

SECTION 62. (1) The Oregon Health Authority may not implement any provisions of this 2011 Act that require federal approval or that require federal approval to receive federal financial participation until the authority has received the approval.

(2) Until the authority has received the approval of the Legislative Assembly under section 13 of this 2011 Act, the authority may not:

(a) Adopt by rule the qualification criteria for a coordinated care organization under section 4 of this 2011 Act or contract with a coordinated care organization;

(b) Adopt by rule a global budgeting process or establish global budgets for coordinated care organizations; or

(c) Implement a process for financial reporting by coordinated care organizations or establish financial reporting requirements under ORS 414.725 (1)(c).

SECTION 63. The amendments to section 8 of this 2011 Act by section 9 of this 2011 Act become operative January 1, 2014.

SECTION 64. (1) ORS 414.705 is repealed.

(2) Sections 13, 14 and 17 of this 2011 Act are repealed January 2, 2014.

(3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739, 414.740 and 414.741 are repealed July 1, 2017.

SECTION 65. Except as provided in section 62 of this 2011 Act, the Director of the Oregon Health Authority may take any action on or after the effective date of this 2011 Act that is necessary to carry out the provisions of this 2011 Act upon the receipt of legislative approval under section 13 of this 2011 Act and federal approval under section 17 of this 2011 Act, including, but not limited to:

(1) Applying for necessary federal approval;

(2) Applying for federal grants; and

(3) Adopting rules.

SECTION 66. **(1) Notwithstanding any other provision of law, the General Fund appropriation made to the Oregon Health Authority by section 1 (2), chapter _____, Oregon Laws 2011 (Enrolled Senate Bill 5529), for the biennium beginning July 1, 2011, is increased by $147,500.**

(2) Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 4 (2), chapter_____, Oregon Laws 2011 (Enrolled Senate Bill 5529), for the biennium beginning July 1, 2011, as the maximum limit for payment of expenses from federal funds, excluding federal funds described in section 2, chapter _____, (Enrolled Senate Bill 5529), collected or received by the Oregon Health Authority is increased by $147,500.

SECTION 67. **Notwithstanding any other provision of law, the General Fund appropriation made to the Department of Human Services by section 1 (3), chapter _____, Oregon Laws 2011 (Enrolled House Bill 5030), for the biennium beginning July 1, 2011, for seniors and people with disabilities, is increased by $960,103.**

SECTION 68. **If House Bill 2100 becomes law, sections 128 (amending ORS 414.025), 129 (amending ORS 414.033), 131 (amending ORS 414.065), 142 (amending ORS 414.705) and 147 (amending ORS 414.725), chapter ___, Oregon Laws 2011 (Enrolled House Bill 2100), are repealed.**

SECTION 69. If House Bill 2100 becomes law, ORS 414.025, as amended by section 1, chapter 73, Oregon Laws 2010, and section 20 of this 2011 Act, is amended to read:

414.025. **Definitions.** As used in this chapter and ORS [*chapter*] **chapters 411 and** 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(3) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for a category of aid but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years and:

(A) Is in a foster family home or licensed child-caring agency or institution and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part; or

(B) Is 18 years of age or older, is one for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act and who met the criteria in subparagraph (A) of this paragraph immediately prior to the person's 18th birthday.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs

of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with [*mental retardation*] **developmental disabilities**.

(k) Is under the age of 22 years and is in a psychiatric hospital.

(L) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(m) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(n) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(o) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(p) Is an individual or member of a group who, subject to the rules of the department **or the Oregon Health Authority**, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(q) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(r) Except as otherwise provided in this section, is a pregnant woman or child for whom federal financial participation is available under Title XIX or XXI of the federal Social Security Act.

(s) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the department [*of Human Services*] **or the authority** by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department **or the authority** by rule.

(t) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(u) Is eligible for the Health Care for All Oregon Children program established in ORS 414.231.

(v) Is dually eligible for Medicare and Medicaid and receiving care through a coordinated care organization.

(4) "Community health worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(5) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under section 4 of this 2011 Act.

(6) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(7) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(8) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health [*Services Commission under ORS 414.720*] **Evidence Review Commission under section 24, chapter ___, Oregon Laws 2011 (Enrolled House Bill 2100)**:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(9) "Income" has the meaning given that term in ORS 411.704.

(10) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department [*of Human Services*] **or the authority** may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(11) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the [*Oregon Health*] authority according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(12) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(13) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under section 6 of this 2011 Act and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(14) "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

(15) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(16) "Personal health navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(17) "Quality measure" means the measures and benchmarks identified by the authority in accordance with section 10 of this 2011 Act.

(18) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, ""resources"" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 70. If House Bill 2100 becomes law, section 64 of this 2011 Act is amended to read:

Sec. 64. (1) ORS 414.705 is repealed.

(2) Sections 13, 14 and 17 of this 2011 Act are repealed January 2, 2014.

(3) ORS 414.610, 414.630, 414.640, 414.736, 414.738, 414.739[,] **and** 414.740 [*and 414.741*] are repealed July 1, 2017.

SECTION 71. If Senate Bill 101 becomes law, section 8, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 101) (amending ORS 414.743), is repealed and ORS 414.743, as amended by section 47 of this 2011 Act, is amended to read:

414.743. (1) **Except as provided in subsection (2) of this section,** a coordinated care organization that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must, using [*a*] Medicare payment methodology, reimburse the noncontracting hospital for services provided to an enrollee of the plan at a rate no less than a percentage of the Medicare reimbursement rate for those services. The percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under this subsection is equal to [*two*] **four** percentage points less than the percentage of Medicare cost used by the authority in calculating the base hospital capitation payment to the plan, excluding any supplemental payments.

(2)(a) If a coordinated care organization does not have a contract with a hospital, and the hospital provides less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the organization, the percentage of the Medicare reimbursement rate that is used to determine the reimbursement rate under subsection (1) of this section is equal to two percentage points less than the percentage of Medicare cost used by the Oregon Health Authority in calculating the base hospital capitation payment to the organization, excluding any supplemental payments.

(b) This subsection is not intended to discourage a coordinated care organization and a hospital from entering into a contract and is intended to apply to hospitals that provide primarily, but not exclusively, specialty and emergency care to enrollees of the organization.

[*(2)*] **(3)** A hospital that does not have a contract with a coordinated care organization to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services the rates described in [*subsection (1)*] **subsections (1) and (2)** of this section.

[*(3)*] **(4)** This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

[*(4)*] **(5)** The Oregon Health Authority shall adopt rules to implement and administer this section.

SECTION 72. If Senate Bill 101 becomes law, section 10, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 101), is amended to read:

Sec. 10. (1) The amendments to ORS 414.826, 414.841 and 414.851 by sections 1 to 4 [*of this 2011 Act*]**, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 101),** become operative January 1, 2012.

(2) The amendments to ORS 414.743 by [*section 8 of this 2011 Act*] **section 71 of this 2011 Act** become operative September 1, 2011.

SECTION 73. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

Passed by House June 27, 2011

Repassed by House June 30, 2011

.....
Ramona Kenady Line, Chief Clerk of House

.....
Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Passed by Senate June 29, 2011

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2011

Approved:

.....M.,....., 2011

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2011

.....
Kate Brown, Secretary of State

Oregon Health Policy Board Action Plan
Key Actions
2011 Legislation and Administrative Actions

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
Set a target for health care spending in Oregon	HB 3650 requires that a Global budget be developed for Coordinated Care Organizations (CCOs) to manage the Medicaid population and dual eligibles' health care services.	*A Call for Nominations was issued by Governor Kitzhaber on June 30, 2011 for 4 work groups, one of which is focused on a Global Budget Methodology for Coordinated Care Organizations (CCOs).*
Standardize certain provider payments to Medicare methodology	SB 204 requires that the Oregon Health Authority (OHA) shall prescribe by rule a uniform payment methodology for hospital and ambulatory surgical center services that incorporates the most current Medicare payment methodology. OHA directed to convene a work group made up of providers, insurers and consumers in developing the payment methodologies. Applies to claims for reimbursement beginning January 1, 2012.	*Work group to be established.*
Focus quality and cost improvement efforts in areas with the greatest potential for improvement to achieve critical momentum.	HB 3650 (Section 10) directs OHA to identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations. The authority is directed to incorporate these measures into coordinated care organization contracts.	*A Call for Nominations was issued by Governor Kitzhaber on June 30, 2011 for 4 work groups, one of which is focused on Outcomes, Quality and Efficiency metrics for Coordinated Care Organizations (CCOs).* *Applications are due no later than 9am on July 15th. The Governor will be selecting members in consultation with Board leadership.*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
Introduce innovative payment methods that reward efficiency and outcomes.	HB 3650 (Section 5) directs OHA to encourage CCOs to use alternative payment methodologies that: (a) Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care; (b) Hold organizations and providers responsible for the efficient delivery of quality care; (c) Reward good performance; (d) Limit increases in medical costs; and (e) Use payment structures that create incentives to: (A) Promote prevention; (B) Provide person centered care; and (C) Reward comprehensive care coordination using delivery models such as patient centered primary care homes. (2) The authority shall encourage coordinated care organizations to utilize alternative payment methodologies that move from a predominantly fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.	*A Call for Nominations issued by Governor Kitzhaber on June 30, 2011 for 4 work groups, one of which is focused on establishing the criteria for qualification as a Coordinated Care Organization (CCO).* *Applications are due no later than 9am on July 15th. The Governor will be selecting members in consultation with Board leadership.*
Reduce administrative costs in health care • Require standardized communication between payers and providers about eligibility, claims, etc. • Create authority to extend	SB 94 creates a work group within OHA to make recommendations to DCBS and OHA on uniform standards for health care financial and administrative transactions. The bill gives authority to DCBS to set standards for all payers, including third party administrators, managed care organizations, clearing houses	*OHA is meeting with representatives of OHLC administrative simplification work group in early July to explore role of work group in SB 94 work.* *The Oregon Health Leadership Council's (OHLC) workgroup (with membership representing OHA)*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
standards to clearinghouses and third party payers	and self-insured plans. Transactions to be addressed are: • Eligibility inquiry and response *(see status)* • Claim submission *(see status)* • Payment remittance advice • Claims payment or electronic funds transfer • Claims status inquiry and response • Claims attachments • Prior authorization • Provider credentialing • Other health care financial and administrative transactions	*creating the Oregon Companion Guides for implementation of the claims transaction set (837) is nearly complete. This is the next step in the Administrative Simplification work that began with the creation of the Oregon Companion Guide for implementation of health care eligibility benefit inquiry and response (270/271) which will be required as of July 1, 2012 for all health plan licensed or doing business in Oregon and health care providers providing services for a fee or as an encounter in Oregon.* *We anticipate approval of the 837 Oregon Companion Guide by the OHLC in early July. Upon approval, the 837 EDI guides will be delivered to DCBS to begin a rulemaking process.*
Decrease obesity and tobacco use • Set nutrition standards for food and beverages in public institutions • Make all state agencies and facilities tobacco-free • Support evidence-based initiatives that reduce tobacco use	Legislation was introduced to require nutrition standards for food and beverage items for sale in public buildings (HB 3224), but the legislation did not receive a hearing.	*OHA is in the process of applying for the Community Transformation Grant which is funded through the ACA. Goals of the grant are to:* • *Reduce death and disability of due to tobacco use by 5% in the implementation areas.* • *Reduce the rate of obesity thorough nutrition and physical activity interventions by 5% in the implementation area.* *Reduce death and disability due to heart disease and stroke by 5% in the implementation area.*
Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange • Establish corporation board and Exchange	SB 99 creates the Oregon Health Insurance Exchange Corporation with direction to present a business plan for approval by the legislature in February.	*A Call for Nominations issued by Governor Kitzhaber on June 30, 2011 for membership on the 9-member Exchange Board of Directors. The deadline for application is 9am on July 15th.* *The OHA Director and DCBS Director or their designees*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
• Receive federal implementation funds		*are members of the Board. Additional members will be appointed by the Governor and confirmed by the Senate.*
Promote local and regional accountability for health and health care	HB 3650 creates Coordinated Care Organizations (CCO), which are community-based organizations that are accountable for care management and provision of integrated and coordinated health care for each organization's members, managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.	*A Call for Nominations was issued by Governor Kitzhaber on June 30, 2011 for 4 work groups, one of which is focused on Coordinated Care Organization criteria.* *Applications are due no later than 9am on July 15th. The Governor will be selecting members in consultation with Board leadership.*
Build the health care workforce • Standardize prerequisites for clinical training via a student "passport." • Use loan repayment to attract and retain primary care providers in rural and underserved areas • Extend requirement to participate in Oregon's health care workforce database to all	• SB 879, the student passport bill, directs OHA to convene a work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon and to report to an interim legislative committee on or before June 30, 2012. • HB 2400, which would have funded the primary care loan repayment program had an estimated fiscal impact of $3.1m in General Fund and did not pass out of the Ways and Means Human Service Subcommittee. • HB 3650 (Section 30) extends OHA's authority regarding the workforce database	*The Workforce Committee has designated a small workgroup to develop a work plan that will be brought to the Workforce Committee meeting on July 27th and then the OHPB for consideration.*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
health professional licensing boards.	to all health professional licensing boards including but not limited to boards that license or certify chemical dependency and mental health treatment providers.	
Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, PEBB, and OEBB) and then statewide	• HB 3650 (Section 6) directs the Oregon Health Authority to establish standards for the utilization of patient centered primary care homes in coordinated care organizations. • HB 3650 also directs each coordinated care organization to implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The organization shall require its other health and services providers to communicate and coordinate care with the patient centered primary care home in a timely manner using electronic health information technology. • Standards established by the authority for the utilization of patient centered primary care homes by coordinated care organizations may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.	• *OHA program staff with the Office for Oregon Health Policy and Research (OHPR) have formed an implementation team that is actively working on implementation steps for moving OHA lives to PCPCHs* • *Standards have been updated to include more detailed focus on children* • *Medicaid is preparing a State Plan Amendment for submission this summer for implementation in October 2011 of the 2 years of the federal dollars available to fund care coordination for a defined set of clients through both the current FFS and MCO contracts* • *The Staff Team has been working on aligning contract language and expectations around PCPCH with each program's managed care plans and/or insurance carriers to the greatest degree possible. Each program will have closely aligned language incorporated into their next contract cycle, effective beginning either October 1, 2011 (DMAP) or January 1, 2012 (PEBB, OEBB, OPHP).* • *Each plan and/or carrier has been asked to estimate the number of practices they anticipate could meet the Oregon PCPCH Standards and corresponding number of OHA-covered lives that receive care in these practices. Some responses have been received, but the data are still incomplete. Staff aim to have more complete baseline estimates by August 1, 2011.*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
	• Each coordinated care organization shall report to the authority on uniform quality measures prescribed by the authority by rule for patient centered primary care homes. Patient centered primary care homes must participate in the learning collaborative described in ORS 442.210.	
Introduce value-based benefit design that removes barriers to preventive care	OHPR continues to build upon the work to develop a value-based benefit design initially envisioned by the Oregon Health Fund Board Benefits Committee and later called for in HB 2009 (2009). The benefit packages based on this design emphasize the reduction of barriers to effective preventive care and chronic disease management through lower cost sharing for value-based services *(having a high preventive component and strong evidence of effectiveness)* or those appearing higher on Oregon's Prioritized List of Health Services.	*An actuarial consultant has completed a model that can estimate premium costs for commercial plans based on cost-sharing parameters reflecting the value-based benefit design. It is anticipated that such benefit packages could be offered both inside and outside of the health insurance exchange under the Affordable Care Act. The model also allows for reimbursement to be altered according to whether the service is value-based or its ranking within the tiers of the Prioritized List. A second model for cost estimates based on OHP utilization will be completed by the end of July.* *OEBB and PEBB have reduced or eliminated cost sharing for value-based drugs used to manage major chronic diseases aimed at preventing complications of the disease and unnecessary hospitalizations. They have also introduced additional copays for preference sensitive treatments that have high cost, high variability in utilization and appear on the lower tiers of the Prioritized List.*
Expand the use of health information technology (HIT) and exchange (HIE) • Consolidate HIE planning and implementation in a single Office of Health Information	HB2101 was filed as a placeholder bill. The rapidly evolving conversations in early 2011 about healthcare transformation raised questions about the timing of establishing the SDE. In February HITOC chose to not move forward with legislation in 2011.	*Office of Health Information Technology (OHIT) has been established. The Health Information Technology Oversight Council (HITOC,) HIE planning and implementation and the Medicaid EHR Incentive Program are currently staffed by OHIT. OHIT staff is also participating where appropriate in the technology*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
Technology (OHIT) • Establish a public-private state-designated entity to connect local, regional and statewide HIE		*planning for health system transformation.* *Without the establishment of a SDE at this time, OHA will continue toward an implementation schedule of initial core services through OHA contracting authority, with the vendor services contract managed by the Office of Health Information Technology. Legislation for SDE designation could occur in the 2012 or 2013 legislative sessions, if determined to be needed.*
Develop guidelines for clinical best practices • Create 10 sets of Oregon-based best practice guidelines and standards of care for use in public and private settings	The development of an initial set of 10 Oregon-based best practice guidelines and standards is intended to build upon the high standards of evidence evaluation and create a more flexible process that will move evidence-based practices rapidly into the clinical setting. The Health Services Commission and Health Resources Commission will continue to work with the Center for Evidence-based Policy in collaboration with other key stakeholders to develop guidelines that can be applied uniformly in public and private settings to reduce unnecessary care and drive down costs. The goal is to complete the first set of ten guidelines in 2011.	*The first guideline, done in collaboration with the Health Leadership Council (HLC) and the Quality Corporation, has been completed for ACUTE LOW BACK PAIN (first 6-12 weeks). The Health Services Commission is reviewing the final draft for endorsement at their August meeting.* *Discussions are underway with HLC and QCorp, as well as within the OHA on how best to enhance communication and use of the guideline with the delivery system and consumers.* *Two other guidelines are currently under the development process working with OHSU's Center for Evidence-based Policy.* *All of the guidelines will have a public input process coordinated with the Health Services Commission. Ongoing partnerships with the HLC and QCorp are anticipated for further topics of mutual interest* http://www.oregon.gov/OHA/OHPR/HSC/docs/GL/Draft-Development.pdf
Strengthen medical liability system by removing barriers to full disclosure of adverse events by providers and facilities and	SB 95 ensures that an insurer cannot refuse to defend a physician being sued for malpractice because the provider disclosed an error to the patient or family. It also amends the apology	*OHA will work with outside consultants to develop the recommendations requested in HB 3650 for the Policy Board and the Legislature to consider over the next few months*

Key Actions OHPB Action Plan for Health	Legislation or other action	Status
clarifying that statements of regret or apology may not be used to prove negligence • Enact law preventing liability insurers from canceling coverage or refusing to defend providers who disclose errors • Amend Oregon's "apology" law	law to clarify that health care employers are also protected by the law.	
Performance measurement • Finalize scorecard with Oregon standard quality measures • Set common standards for diversity data in OHA systems	NA	*A Call for Nominations was issued by Governor Kitzhaber on June 30, 2011 for 4 work groups, one of which is focused on Outcomes, Quality and Efficiency metrics for Coordinated Care Organizations (CCOs). Elements of the statewide scorecard will be developed after completion of this work.* *Draft OHA policy establishing common definitions and collection of race and ethnicity data have been presented to the OHA/DHS Joint Policy Steering Committee for approval and adoption..*

Oregon's Path Toward Health System Transformation

Oregon Health Policy Board
July 12th, 2011

July 2011 – February 2012
Work Plan

Oregon Health Authority

Oregon's path to health reform

- 2005: Westlund-Bates Senate Special Committee on Health Care Reform created
- 2007: Oregon Health Fund Board (OHFB) established
- 2008: OHFB state-wide community meetings. Solutions analyzed. Plan developed and presented to Legislature
- 2009: Oregon Health Authority and Oregon Health Policy Board launch and begin implementing next phase: Healthy Kids, OHP Standard expansion, HB 2009
- 2010: Federal reform enacted. Oregon Health Policy Board hosts state-wide community meetings and submits Oregon Action Plan for Health to Legislature in December 2010
- 2011: Oregon Health Policy Board and Governor Kitzhaber charter Health System Transformation Team (HSTT)
- 2011: Legislature passes major health reform proposals reflecting Action Plan and Health System Transformation Team recommendations:
  - HB 3650: Health System Transformation
  - SB 99: Oregon Health Insurance Exchange

Oregon Health Authority

Oregon Health Policy Board

Action Plan identifies 8 key strategies for achieving the Triple Aim and delivery system reform:

1. Reduce costs and improve value and quality by using our purchasing power to change how we deliver and pay for health care;
2. Establish an Oregon Health Insurance Exchange to increase access to affordable health insurance for individuals and small businesses;
3. Shift our focus to prevention;
4. Improve health equity;

Oregon Health Authority

Action Plan identifies 8 key strategies for achieving the Triple Aim:

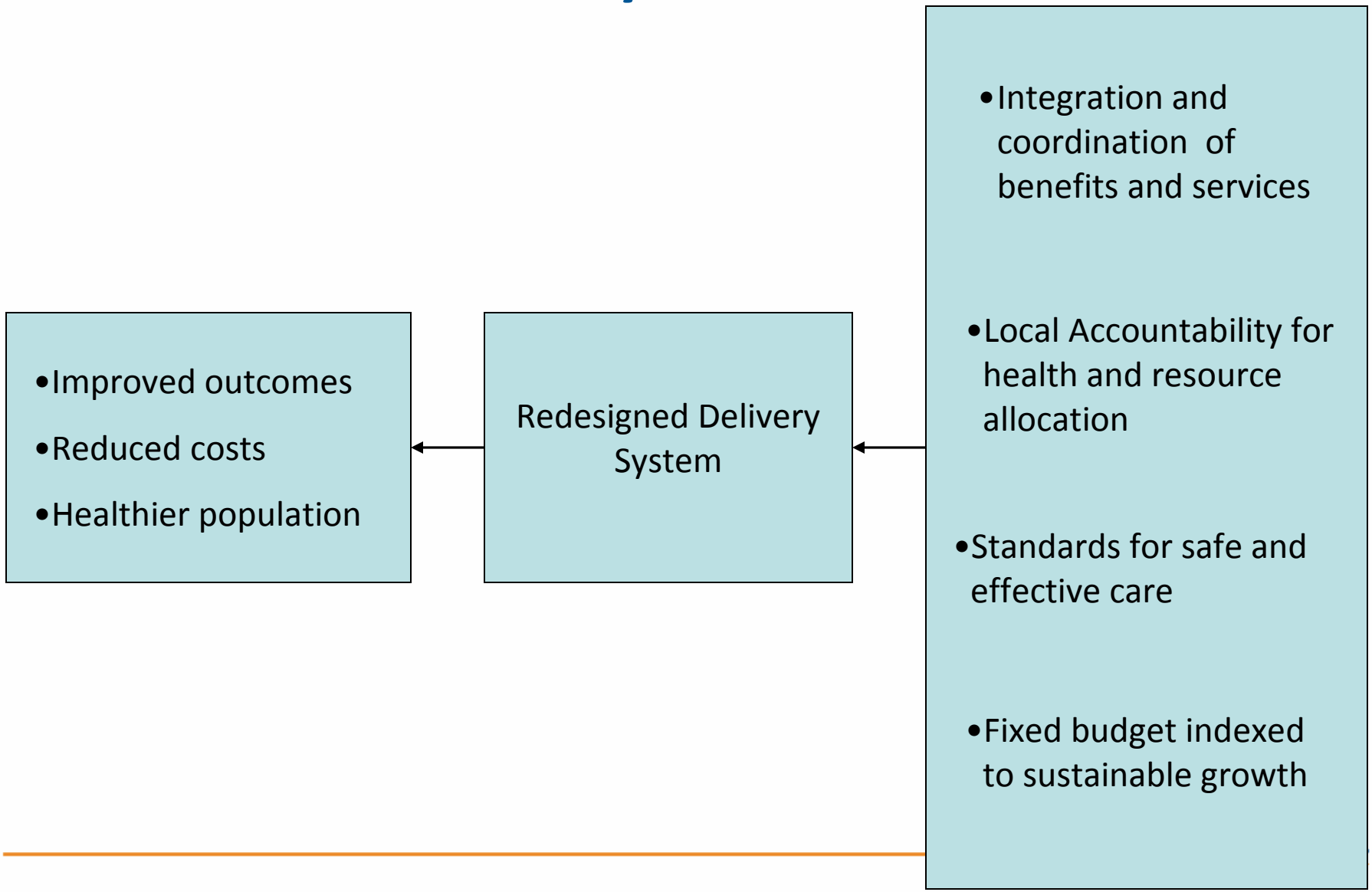
5. Build and retain a health care workforce for Oregon;
6. Set standards for safe and effective care;
7. Promote and develop regional accountability for health and health care;
8. Measure progress with sound metrics

Key Actions identified as Board priorities.

See attached crosswalk.

Oregon Health Authority

Oregon Health Policy Board's Theory of Change HB 3650: Health System Transformation



Oregon Health Policy Board's Theory of Change HB 3650: Health System Transformation

Section 2: There is established the Oregon **Integrated and Coordinated** Health Care Delivery System. The system shall consist of state policies and actions that make coordinated care organizations accountable for care management and provision of integrated and coordinated health care for each organization's members, **managed within fixed global budgets**, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of **regional and community accountability** for the health of the residents of each region and community, and while **maintaining regulatory controls necessary to ensure quality** and affordable health care for all Oregonians.

Oregon Health Authority

NEXT STEPS

Health System Transformation Work groups

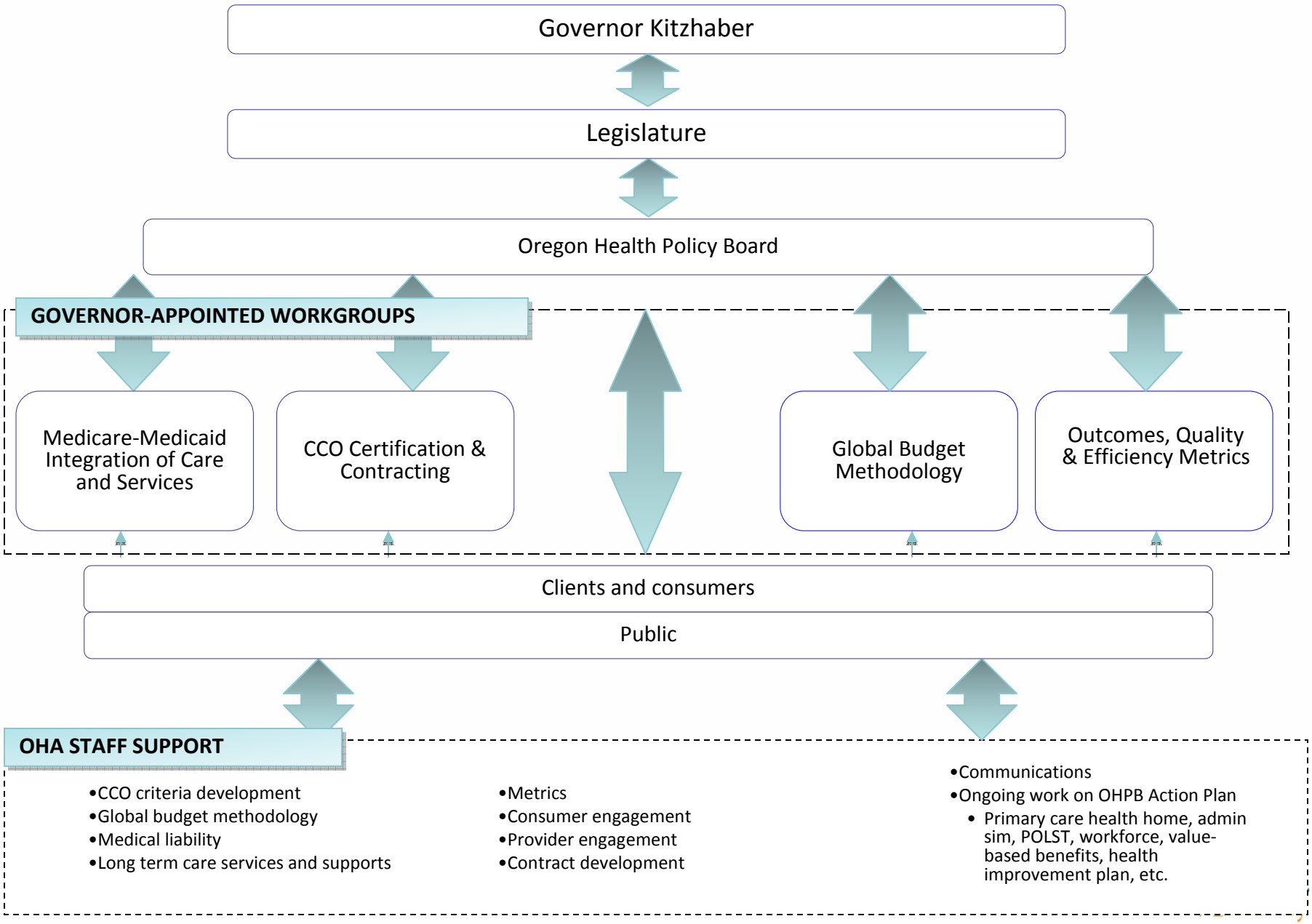
- Coordinated Care Organization Criteria
- Global Budget Methodology
- Outcomes, Quality and Efficiency Metrics
- Medicaid and Medicare Integration of Care and Services

Governor Kitzhaber is seeking nominations for work group members who are committed to transformational change. In order to apply, interested individuals must download, complete and submit an Executive Appointments Interest Form.

Go to http://health.oregon.gov for detailed information about each of the work groups, instructions for applying, and links to the Interest Form.

Deadline for application: 9 a.m. on Friday, July 15, 2011.

Oregon Health Authority


Governor Kitzhaber
Legislature
Oregon Health Policy Board
GOVERNOR-APPOINTED WORKGROUPS
Medicare-Medicaid Integration of Care and Services
CCO Certification & Contracting
Global Budget Methodology
Outcomes, Quality & Efficiency Metrics
Clients and consumers
Public
OHA STAFF SUPPORT
•CCO criteria development
•Global budget methodology
•Medical liability
•Long term care services and supports
•Metrics
•Consumer engagement
•Provider engagement
•Contract development
•Communications
•Ongoing work on OHPB Action Plan
• Primary care health home, admin sim, POLST, workforce, value-based benefits, health improvement plan, etc.

Work Groups: CCO Criteria

OHPB : integration and coordination of benefits and services; local accountability for health and resource allocation

HB 3650 charge (Section 4):

In addition, HB 3650 directs OHA to:

- Encourage CCOs to adopt alternative payment methodologies (Section 5)
- Establish standards for the utilization of patient-centered primary care homes in CCOs (Section 6)
- Seek CMS authorization for CCOs to provide services to dually eligible individuals (Section 7)
- Adopt consumer and provider protections for those enrolled in CCOs (Section 8)

Oregon Health Authority

Work Groups: CCO Criteria

Charter includes:

- The CCO Criteria work group is charged with providing input on design and implementation considerations for the statement of work and certification criteria for CCOs, including:
  - Benefits covered
  - Population(s) to be enrolled
  - Access across full spectrum of services and care
  - Patient engagement and care management
  - Ensuring health equity
  - Health information technology and information exchange
  - Quality improvement
  - Financial management and risk management
- The work group will seek input from the work group on Medicare-Medicaid Integration of Care and Services on criteria relating to coordination of health care and long-term care services for dual eligibles.
- The group will not provide input on the establishment of global budgets.
- Co-chairs: Mike Bonetto, Health Advisor to the Governor.
  Bruce Goldberg, OHA Director.

Oregon Health Authority

Work Groups: CCO Criteria

Additions? Considerations?

Oregon Health Authority

Work Groups: Global Budget Methodology

OHPB: fixed budget indexed to sustainable growth

HB 3650 (Section 13) directs OHA to develop:

A global budgeting process for determining payments to coordinated care organizations and for revising required outcomes with any changes to global budgets;

Oregon Health Authority

Work Groups: Global Budget Methodology

Charter includes:

- The work group will provide input on design and implementation considerations for the CCO global budget, including:
  - Proposed overall approach to calculation of the global budget.
  - Proposed program, populations, and funding sources to be included in the initial global budget and input for sequencing of additional components in subsequent years.
  - Global budget risk adjustment or stratification options that could be included to address concerns regarding enrollment and other risk considerations.
  - Analysis of approach for including Medicare funding stream for non-long term care costs of full dual eligibles.

- Co-chairs: Mike Bonetto, Health Advisor to the Governor
  Bruce Goldberg, OHA Director

Oregon Health Authority

Work Groups: Global Budget Methodology

Additions? Considerations?

Oregon Health Authority

Work Groups: Outcomes, Quality and Efficiency Metrics

OHPB: standards for safe and effective care

HB 3650 (Section 10):

The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks for all health services provided by Coordinated Care Organizations.

Oregon Health Authority

Work Groups: Outcomes, Quality and Efficiency Metrics

Charter includes:

- The work group will provide input on performance indicators and standards that can be used to help assess whether CCOs are improving health, making quality care accessible, and controlling costs.
- The work group will advise OHA on: a) performance indicators for both short and long term; b) appropriate methods for setting performance targets; and c) an effective process for introducing and retiring indicators.
- The work group will seek input from the work group on Medicare-Medicaid Integration of performance indicators relating to coordination of health care and long-term care services for dual eligibles.
- The group will not provide input on issues related to global budgets, risk adjustment, or contractual criteria.
- Co-chairs: Tina Edlund, OHA Chief of Policy
  Sean Kolmer, Assistant Health Policy Advisor to the Governor

Oregon Health Authority

Work Groups: Outcomes, Quality and Efficiency Metrics

Additions? Considerations?

Oregon Health Authority

Work Groups: Medicaid-Medicare Integration of Care and Services

OHPB: integration and coordination of benefits and services

HB 3650 (Section 7):

- The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care.
- Coordinated care organizations are responsible for providing covered Medicare and Medicaid services to members who are dually eligible for Medicare and Medicaid.

Oregon Health Authority

Work Groups: Medicaid-Medicare Integration of Care and Services

Charter includes:

- The Work Group is charged with providing input on, relative to delivery of care and services to dual eligibles,
  - Criteria for coordinated care organizations and contractual requirements of CCOs;
  - Performance metrics relating to integration of health care and long-term care services for dual eligibles;
  - Alignment of Medicare and Medicaid requirements for CCOs to reduce administrative cost and enable CCOs to offer a single integrated program to dual eligibles.
- The group will not provide input on the establishment of a global budget.
- Co-chairs: TBD

Work Groups: Medicaid-Medicare Integration of Care and Services

Additions? Considerations?

Oregon Health Authority

Cost of Defensive Medicine

HB 3650 directs OHA to develop recommendations for containing health care costs attributable to defensive medicine and overutilization of services.

Work should address:

- **Cost of defensive medicine within Oregon and potential savings from recommended changes;**
- **Benefits and impact of malpractice caps on medical liability premiums and of binding and non-binding medical panels to address claims of malpractice;**
- **Provider self-referral practices including an examination of Stark laws exceptions and exemptions;**
- **A path for a cap on damages for those acting on behalf of the state and serving individuals receiving medical assistance services.**

Oregon Health Authority

Work Plan and Process: July to February

- Six Board meetings between now and February legislative session
- Stakeholder engagement plan in development
- Staff will work with 4 work groups and on to develop proposals in an iterative process with Board at each meeting
- Staff will work with consultants to assess the costs of defensive medicine and develop proposals to mitigate impact to bring to Board
- Workforce committee will develop strategic plan for primary care and uniform standards for student clinical placement
- Health system transformation recommendations from the Board go to Legislature for review and approval in February

Oregon Health Authority

Health System Transformation Work groups
and
Oregon Health Insurance Exchange Corporation Board

CALL FOR NOMINATIONS

In order to apply, interested individuals must download, complete and submit an Executive Appointments Interest Form.

Go to http://health.oregon.gov for detailed information, instructions for applying, and links to the Interest Form.

Deadline for application: 9 a.m. on Friday, July 15, 2011.

Oregon Health Authority

Oregon Health Policy Board
Coordinated Care Organization Criteria for Qualification
Work Group

Approved by OHPB on [date]

I. Authority

The Oregon Health Authority (OHA), under House Bill 3650, Section 13, is establishing a meaningful public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan. As the policy-making and oversight body for OHA, the Oregon Health Policy Board (Board) establishes the Coordinated Care Organization (CCO) Criteria Work Group to provide input on statement of work and certification criteria. The Work Group will be guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs.

This charter shall expire on December 31, 2011 or when the Board determines that the charter has been fulfilled, whichever is sooner.

II. Work Group Membership

CCO Criteria workgroup members are appointed by and will serve at the pleasure of the Governor. Please see following page(s) for a list of Work Group membership.

III. Scope

The CCO Criteria workgroup is charged with providing input on design and implementation considerations for the statement of work and certification criteria for CCOs, including:

- Benefits covered
- Population(s) to be enrolled
- Access across full spectrum of services and care (excluding long term care services)
- Patient engagement and care management
- Ensuring health equity
- Health information technology and information exchange
- Quality improvement

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- Financial management and risk management

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

The Work Group will seek input from the Work Group on Medicare-Medicaid Integration of Care and Services on criteria relating to coordination of health care and long-term care services for dual eligibles. The group will not provide input on issues related to the establishment of global budgets.

This group will not be asked to approve or disapprove the final Board recommendations to the Legislature.

IV. Timing/Schedule

The Workgroup will be complete by November, 2011. Criteria will be developed to assure CCO capacity to perform in the areas identified in the statement of work. These criteria will address organizational characteristics and capacities as well as performance standards.

V. Staff Resources

Co-chairs: Mike Bonetto, Health Advisor to the Governor, and Bruce Goldberg, OHA Director
Staff: Bob DiPrete, OHA

VI. Work Group Membership

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Oregon Health Policy Board
Global Budget Methodology Work Group

Approved by OHPB on [date]

I. Authority

The Oregon Health Authority (OHA), under House Bill 3650, Section 13, is establishing ameaningful public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan. As the policy-making and oversight body for OHA, the Oregon Health Policy Board (Board) establishes the Global Budget Methodology Work Group to provide input on the development of methodology used to create Coordinated Care Organization (CCO) global budgets. The Work Group will be guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs.

This charter shall expire on December 31, 2011 or when the Board determines that the charter has been fulfilled, whichever is sooner.

II. Work Group Membership

The Global Budget Methodology workgroup members are appointed by and will serve at the pleasure of the Governor. Please see following page(s) for a list of Work Group membership.

III. Scope

The Global Budget Methodology workgroup is charged with providing input on design and implementation considerations for the CCO global budget approach including:

(1) Proposed overall approach to calculation of the global budget.
(2) Proposed program, populations, and funding sources to be included in the initial global budget and input for sequencing of additional components in subsequent years.
(3) Global budget risk adjustment or stratification options that could be included to address concerns regarding enrollment and other risk considerations.
(4) Analysis of approach for including Medicare funding stream for non-long term care costs of full dual eligibles.

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

This group will not be asked to approve or disapprove the final Board recommendations to the Legislature.

IV. Timing/Schedule

The Workgroup will be complete by November, 2011. The current schedule proposes four meetings of the Global Budget Methodology Workgroup.

Meeting #1, date TBD	• Initial review of proposed overall approach to global budget calculations and potential programs, populations, and funding sources to be included.
Meeting #2, date TBD	• Second review of proposed overall approach and funding included in global budget • Initial review of work to date of adjustment options and Medicare funding approaches.
Meeting #3, date TBD	• Review of budget methodology including adjustment options • Second review of Medicare approach and calculations
Meeting #4, date TBD	• Review of full analysis developed to date

V. Staff Resources

Co-chairs: Mike Bonetto, Health Advisor to the Governor, and Bruce Goldberg, OHA Director
Staff: Gretchen Morley, Acting Deputy Administrator, and Russell Voth, Policy Analyst, OHPR

VI. Work Group Membership

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Oregon Health Policy Board
Outcomes, Quality & Efficiency Metrics Work Group

Approved by OHPB on [date]

I. Authority

The Oregon Health Authority (OHA), under House Bill 3650, Section 13, is establishing a meaningful public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan. As the policy-making and oversight body for OHA, the Oregon Health Policy Board (Board) establishes the Outcomes, Quality & Efficiency Metrics Work Group to provide input on performance indicators for Coordinated Care Organizations. The Work Group will be guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs.

This charter shall expire on December 31, 2011 or when the Board determines that the charter has been fulfilled, whichever is sooner.

II. Work Group Membership

Members of the Outcomes, Quality & Efficiency Metrics Work Group are appointed by and will serve at the pleasure of the Governor. Please see following page(s) for a list of Work Group membership.

III. Scope

The Outcomes, Quality & Efficiency Metrics Work Group is charged with providing input on performance indicators and standards that can be used to help assess whether Coordinated Care Organizations (CCOs) are improving health, making quality care accessible, and controlling costs. The Work Group will advise OHA on: a) performance indicators for both short and long term; b) appropriate methods for setting performance targets; and c) an effective process for introducing and retiring indicators.

The Work Group will seek input from the Work Group on Medicare-Medicaid Integration of Care and Services on performance indicators relating to coordination of health care and long-term care services for dual eligibles. The group will not provide input on issues related to the

establishment of global budgets, including risk adjustment, or on contractual criteria for CCOs beyond those related to performance measurement.

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

This group will not be asked to approve or disapprove the final Board recommendations.

IV. Timing/Schedule

The Workgroup will be complete by November, 2011. The current schedule proposes four meetings with topics including.

- Performance indicators
- Benchmarking methodology
- Implementation staging and planning framework

V. Staff Resources

Co-chairs: Tina Edlund, OHA Chief of Policy, and Sean Kolmer, Assistant Health Policy Advisor to the Governor

Staff support: Lisa Angus, Office for Oregon Health Policy & Research

VI. Work Group Membership

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Oregon Health Policy Board
Work Group on Integration of Care for Individuals Eligible for both Medicare and Medicaid

Approved by OHPB on [date]

I. Authority

The Oregon Health Authority (OHA), under House Bill 3650, Section 13, is establishing a meaningful public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan. As the policy-making and oversight body for OHA, the Oregon Health Policy Board (Board) establishes the Advisory Group on Integration of Care for Individuals Eligible for both Medicare and Medicaid to provide input on issues relating specifically to those who are dually eligible for OHP and Medicare. The advisory group will be guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by the Triple Aim of improving population health, improving the individual's experience of care and reducing per capita costs.

This charter shall expire on December 31, 2011 or when the Board determines that the charter has been fulfilled, whichever is sooner.

II. Work Group Membership

Members of the Work Group on Integration of Care for Individuals Eligible for both Medicare and Medicaid are appointed by and will serve at the pleasure of the Governor. Please see following page(s) for a list of Work Group membership.

III. Scope

The Work Group is charged with providing input on, relative to delivery of care and services to dual eligibles,

1. Criteria for coordinated care organizations and contractual requirements of CCOs;
2. Performance metrics relating to integration of health care and long-term care services for dual eligibles;
3. Alignment of Medicare and Medicaid requirements for CCOs to reduce administrative cost and enable CCOs to offer a single integrated program to dual eligibles.

This group will not provide input on issues relating to establishment of global budgets for CCOs.

This group will not be asked to approve or disapprove the final proposal submitted to CMS.

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

IV. Timing/Schedule

The Workgroup input as it relates to the work outline in HB 3650 will be complete by November, 2011.

V. Staff Resources

Co-chairs: TBD
Staff: Lynn Marie Crider, Office for Oregon Health Policy & Research

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VI. Work Group Membership

	Name	Institution
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Health Information Technology Oversight Council

Report to OHA Director, July 1st, 2011

Below is a summary of HITOC and related workgroups, panels and stakeholder meetings since April 26th, 2011. Full meeting summaries are available through the Office of Health Information Technology (OHIT).

April 27th, Finance Workgroup: Staff presented an expanded savings analysis related to the adoption and use of Health Information Exchange (HIE). Members identified a need for further examination of the methods and assumptions of the savings analysis. The workgroup acknowledges that the anticipated State Medicaid Directors Letter and Office of the National Coordinator of Health IT (ONC) Program Information Notice will inform Oregon's HIE financing plan.

May 5th, HITOC: Oregon's (HIE) Cooperative Agreement federal partner from ONC attended the meeting as a part of their site visit to Oregon. Staff presented information on the Direct Project and discussed Oregon's Health Information Services Provider (HISP) that will make HIE available to all providers statewide. The HITOC Director announced that on September 14th 2011, Oregon will host the AIM Conference with National Coordinator for Health IT, Farzad Mostashari, as the keynote speaker. Members acknowledged change management is an important component for HIE implementation in the near-term. Members discussed possible links between HIE and health system transformation efforts in Oregon.

May 12th, e-Prescribing ad hoc Group: Staff and group members reviewed and analyzed results from the Independent Pharmacy Survey, the Hospital Survey, Chain Pharmacy outreach, and Surescripts data. The group identified adoption barriers for independent pharmacies and hospital pharmacies, as well as issues of limited state planning and outreach resources. Several strategies were suggested to address issues and barriers, staff will continue work to formalize these strategies.

May 13th, Labs ad hoc Group: Staff presented an initial report on the first lab survey to the group. The group developed an initial outreach strategy geared toward increasing electronic laboratory results reporting among targeted groups.

June 2nd, HITOC: Staff presented an initial analysis of the May 18th State Medicaid Directors Letter (SMD). The Council discussed the Fair Share Principle described in the SMD and considered the potential financial implications of the SMD. The Council tasked the Finance Workgroup with addressing some issues and questions raised for Oregon's HIE finance plan. Staff updated the Council on the progress of Oregon's HIE technology request for proposal (RFP) that will be issued in July.

June 15th, Legal & Policy Workgroup: Staff updated members on the consent policy for HIE in Oregon. Members discussed the progress of the HIE Participation Agreement subcommittee toward developing a contract for users of statewide HIE services. Staff announced that invitation to participate in the Rules Advisory Committee for the consent policy will be sent soon. The workgroup provided input on how best to educate providers on the new administrative rules.

June 27th, Finance Workgroup: Staff presented a financial analysis of the impact of the SMD on the HIE budget. Staff presented issues and questions HITOC raised at its June 2nd meeting. Members discussed

the Fair Share Principle described in the SMD that outlines financial participation by stakeholders as a requirement for maximizing Medicaid federal financial participation (FFP) in funding HIE. Members proposed that stakeholders will need more information on HIE resource needs and that additional research on regional HIO services should be conducted. Additional work in developing straw plans will be completed during the summer.