Health Information Technology Oversight Council

Thursday, May 5th, 2011

Oregon State Library, Rooms 102-103
250 Winter St NE
Salem OR 97301

DRAFT Meeting Agenda

1:00 pm Opening and Welcome – Steve Gordon, MD

- Approval of minutes from April 7th HITOC meeting

1:05 pm Meeting Overview and Outcomes – Carol Robinson

- Share and learn with ONC
- Finalize Emergency Consent Policy
- Discuss launch phase

1:10 pm Updates

- National Update – Carol Robinson, Sheetal Shah, Ross Marti
- Governor's Update – Sean Kolmer
- O-HITEC Report
- EHR Incentives Program Update – Susan Otter

2:00 pm Accelerate-Innovate-Motivate – the next 8 months

- Program Overview – Carol Robinson
- Developing Strategies- Julie Harrelson, Chris Coughlin
    - Annual conference
    - Grant Program for Pilots
    - Communication and marketing
    - Brainstorming with HITOC, Workgroup & Panels
- Technology Plan and Launch – John Hall
    - Q and A with HITOC

3:00 pm Break

3:15 pm Finance – Dave Witter

3:45 pm Consumer Advisory Panel – Bob Brown

4:10 pm Public Comment

4:30 pm Vote on Emergency Consent Policy

4:40 pm Closing Comments – Steve Gordon, Carol Robinson

5:00 pm Close

Technology Workgroup Meeting
Summary Progress Report

Staff Present: Carol Robinson, Kahreen Tebeau, Dave Witter, Luke Glowasky, John Hall, Mindy Montgomery, Julie Harrelson, Chris Coughlin, Chelsea Hollingsworth, Nan Robertson, James McCormack
Report Prepared by: Luke Glowasky
Meeting Date: April 20, 2011
Primary Meeting Focus: Provider directories, content standards
Workgroup Members Present: Brian Ahier (chair), Aaron Karjala (vice chair), Kent Achterhof, Hongcheng Zhao, Leeta Anderson, Patricia Van Dyke, Ellen Larsen, JA Magnuson, Susan Woods, John Dunn, Eric McLauglin (phone)
Workgroup Members Absent: Paul Matthews
Other Attendees: Nan Robertson (eRx Stakeholder Group), James McCormack (Labs Stakeholder Group)

Progress Status Summary: Staff presented updates on HITOC and the other workgroups and panels, Oregon's Health System Transformation Team, and the Direct Project, including information from the recent ONC Direct Boot Camp. The workgroup discussed Individual Level Provider Directories (ILPDs), and identified potential challenges, opportunities and strategies for implementing the statewide HIE Core Service ILPD. The group received updates from the eRx and Labs Stakeholder Groups, and then discussed content standards for exchange.

Discussion Highlights:

- **Direct Project:** Direct Project's internet-based secure messaging is a key part of Oregon's HIE Core Services strategy, and has been incorporated into the HIE plans of nearly 40 states and territories. Use cases of lab results and clinical summary sharing are two key targets of the Direct Project. There are opportunities for organizations in Oregon to build and participate in Direct Pilot projects. The group suggested Direct messaging between HIOS as a potential use case for a pilot.

- **ONC Direct Boot Camp:** three day symposium to assist states with approved (or near-approved) strategic & operational plans that incorporate Direct and/or move toward implementation of Direct. Consisted of various focused sessions with topics ranging from the basic anatomy of Direct to privacy and security issues, as well as working sessions with the states. Key takeaways from the boot camp were:
    - HISP services: for the Direct Project a HISP is an organization that provides services on the Internet to facilitate Direct messaging. A question states are wrestling with is to what degree the State or SDE should provide HISP services compared to monitoring external HISPs through qualification.
    - Thin-level HIE service strategies: some states are realizing that their HIE plans were overambitious regarding the robustness of their service infrastructures, and are now pursuing more thin-layer infrastructures. How to wield Direct as a low-cost transportation mechanism to support thin-layer service strategies is a key consideration.

- **Provider directories:** the ONC HIT Policy Committee (HITPC) approved recommendations for ILPDs in March 2011. In contrast to the recommendations for Entity Level Provider Directories (ELPDs), the committee advocated not having a national framework with considerable standards, since this would likely create a burden to the many state ILPD efforts already underway. Initially (in Phase 1), Oregon's ILPD will be a relatively thin-layer service providing at a minimum the functionality to enable routing and address discovery for HIE participants. Opportunities to expand the ILPD for other uses including public health and credentialing were suggested, and it was agreed that the ILPD should have the capacity to expand in the future. Value-based services provided by the ILPD could entice participation in HIE and eventually provide a revenue stream to

support financial sustainability. Having a method for ensuring accuracy of the data will be important; to ensure the value of the service and confidence in HIE.

- **eRx Stakeholder Group update:** key objectives of this group are to define strategies and objectives to increase eRx adoption; design, conduct, and analyze a survey of Oregon hospital pharmacies, and a survey of independent pharmacies; develop an action plan to enhance eRx adoption; and define metrics to assess and monitor progress. As of April 2011, both surveys are underway. While there is a Meaningful Use objective for Eligible Hospital pharmacies to do e-prescribing, the only incentive for independent pharmacies is securing the business of providers that e-prescribe.

- **Labs Stakeholder Group update:** key objectives of this group are to define strategies and objectives to enhance lab interoperability, produce and analyze an environmental scan via survey, develop an action plan to increase electronic lab reporting adoption, and then define metrics to assess and monitor progress. The survey of moderate to high complexity labs in Oregon is currently in the field and receiving a relatively high response rate. Among other things the survey seeks to identify the multiple forms of electronic reporting that labs are doing, and also identify any drivers or barriers for labs joining an HIE. With no Meaningful Use incentives for labs to join HIEs, there are not any apparent drivers outside of regular business incentives.

- **Standards & Interoperability (S&I) Framework:** the S&I framework is a set of integrated functions, processes, and tools being guided by the healthcare and technology industry to achieve harmonized interoperability for HIE. The work is organized around initiatives, with each initiative focusing on a single challenge, developing content, technology specifications, and reusable tools and services to enhance healthcare. Initiatives include:
    - CDA consolidation: launched to harmonize the numerous CDA implementation guides upon which C32 and other clinical content specifications are based in order to identify and address impacts to implementation.
    - Transitions of care: focusing on supporting all transitions of care with a common modular set of data that can be used both in a document context and to inform downstream clinical decisions (medication reconciliation, updating problem, allergy lists, decision support, etc.)
    - Lab results interface: launched to address the challenge of lab reporting to ambulatory primary care providers.

- **State HIE Lab Interoperability CoP:** comprised of approximately 70 members, including State HIT Coordinators and other key state stakeholders working to advance lab interoperability in their state. Short-term objectives focus on lab results delivery, including developing standardized contract language for EHR contractors and lab IT procurements and defining regulations that relate to or may potentially hinder laboratory participation in HIE. The long-term objections focus on issues related to lab orders.

Meeting Outcomes:

- Members are familiar with the HITPC recommendations for ILPDs, the proposed phased approach for implementing an ILPD in Oregon's statewide HIE, and the status of the Labs and eRx Stakeholder Groups.
- Members are aware of the various initiatives related to HIE and content standards that are available for participation, including the S&I initiatives and State HIE Lab Interoperability CoP.

Next Steps:

- The next Technology Workgroup meeting is on Thursday, May 12, 2011. The agenda will include a discussion of the technology RFP for Oregon's HIE services.

Challenges/Opportunities:

- Building and implementing a robust, thin layer ILPD service for Oregon's HIE that can be usable in 2011 will provide the necessary capability for expansion and reusability.

Other Workgroup Interdependencies:

- None at this time.

Public Comment:

- None at this time.

Out of Scope, But Needs Attention:

- None at this time.

HITOC input:

- None at this time.

Consent Policy for HIE in Medical Emergencies

Recommendation from the Legal & Policy Workgroup and feedback from the Consumer Advisory Panel

The recommendation on the HIE Consent Policy and Implementation Plan approved by HITOC at the January 2011 meeting (Opt out with Exceptions) does not address the specific case of medical emergencies. Most states developing additional consent policies for HIE treat medical emergencies as a special case that needs to be explicitly addressed, separate from the general consent policy.

The Consumer Advisory Panel discussed this at their Jan. 27, 2011 meeting and provided input to the Legal & Policy Workgroup, which formulated a formal recommendation for HITOC at their Feb. 16, 2011 meeting.

1. Legal & Policy Workgroup

1a. Recommendation to HITOC

The Workgroup members voted 7 in favor to 2 opposed for the following policy for consent for HIE in the case of medical emergency:

- *If a patient opts-out of HIE, or if a patient with SPHI does not affirmatively opt-in, there will not be an exception or over-ride of this choice for the case of a medical emergency, and the patient's health data will not be sent via HIE to the emergency medical provider.*

The two members who opposed the above policy favored allowing exceptions for the case of medical emergency, but emphasized that the definition of "medical emergency" would need further clarification.

1b. Legal & Policy Workgroup Discussion Highlights

- The definition of a "medical emergency": Various alternative definitions were discussed; Workgroup members agreed that:
  - the language preferred by the Consumer Advisory Panel which stipulated that a medical emergency must be "life threatening" was too restrictive;
  - emergency situations occur in various contexts, not just the hospital's emergency department;
  - the treating medical professional should have discretion over determining whether something qualifies as a medical emergency; and
  - Workgroup members would provide alternative definitions for "medical emergency", (which were submitted and have been compiled- see section 1c below).
- Consumer perspectives (from the Consumer Advisory Panel and national research) on whether, if they had already opted-out of HIE, would they like their protected health information (PHI) disclosed via HIE in the case of medical emergency
- How disclosure of PHI via HIE would work operationally in the case of a medical emergency:
  - In the short-to-medium term, it will operate in a "push" environment where the emergency personnel would have to know where to seek the patient's health records, and the patient's various providers would have to send the information to the emergency treating provider—it would work very similarly to how fax currently works today. The general differences still apply- namely that HIE happens over the internet, and that the entire record is sent rather than redacted portions of a record.

- However, in the longer term we should be prepared to transition into a query or "pull" environment, and the policies we develop now should be extendable to that environment to the greatest extent possible.

- Whether having two different policies around consent for HIE (one for "general" healthcare situations, and one for "emergency" situations) could create confusion, and the extent/type of education necessary to mitigate this confusion.
- The potential negative impact on participation in HIE if exceptions to a patient's choice to opt-out are made for the case of emergencies.

1c. Alternative definitions of "medical emergency" provided by Legal & Policy Workgroup Members:

- A medical emergency is an injury or illness that is acute and poses an immediate risk to a person's life or long term health.

- "'Emergency' means a health condition or illness that, if immediate medical attention is not provided, can be expected to result in death, serious impairment to bodily functions, dysfunction of a body organ or part or irreversible deterioration of long-term health."

- The following is from the federal drug and alcohol confidentiality law, 42 CFR Part, Subpart D, Section 2.51:" . . . patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention."

2. Consumer Advisory Panel

2a. Input to the Legal & Policy Workgroup:

The majority of Consumer Advisory Panel members (10 of 11) agreed that:

- *For life-threatening medical emergencies, a patient's protected health information (PHI) should be shared with the treating physician/emergency responder, even if the patient has opted out of HIE, or has not opted in (for those patients with specially protected health information).*

The one dissenting opinion was expressed as follows:

- "A patient's wishes should apply across the board. I prefer an opt-in model, but recognize that opt-out is probably the best we are going to get. That being the case, opt-out should NEVER be overridden. The ER story sounds compelling, but the reality is much more complex."

2b. Consumer Advisory Panel Discussion Highlights:

- If/how sending a patient's health data via fax is any different than sending it via HIE
- "Medical emergency" needs to be clearly defined as life-threatening.
- We have to take into account not only the Emergency Department of hospitals receiving the patient's data via HIE for emergency treatment, but also emergency medical responders/EMTs in the field.
- The consent policy for medical emergencies, whether it's different or not from the general consent policy, should be explicitly and clearly explained to patients along with the other consent policy information they receive at or before their first visit to a new provider/entity.
- In emergency situations, the majority of the Panel felt that both the treating physician and sending physician would want clear guidelines that allow them to access and disclose (respectively) a patient's health data, because they would want what's best for the patient, there's an obligation on the part of Emergency Departments to treat patients who are admitted, and there are significant liability issues.

HITOC Labs Survey, April 2011
Progress Summary

In order to better understand the issues related to the electronic transmission of structured lab results, HITOC invited a group of laboratory stakeholders to join an advisory workgroup dedicated to HIT issues related to labs. The group was tasked to identify and recommend to the Technology Workgroup a strategic plan to improve the adoption and use of electronic laboratory reporting in Oregon.

The Labs Stakeholder group is currently surveying Oregon labs. The group has invited approximately 120 laboratory managers to participate in the online survey. The survey was distributed on April 13, 2011 and will close on May 9, 2011. The purpose of the survey is to assess the capabilities of a sample of CLIA certified laboratories in Oregon to send structured and secure electronic laboratory results to authorized providers outside of their organization (i.e. providers outside of their clinic, hospital, health system, or provider network). The survey asks various questions regarding current report distribution practices (paper, fax, electronic, etc.), technical capabilities for electronic reporting, policy and regulation, efforts to support Meaningful Use objectives among partners and facilitators, and barriers to lab participation in Health Information exchange. Following the close of the survey, the Labs Stakeholder Group will analyze the survey results and use them for guidance in developing an action plan to increase the adoption of electronic laboratory reporting that will be recommended to the Technology Workgroup.

Oregon Health Information Technology Oversight Council

Health Information Exchange Adoption Impact: Potential Avoidable Services Impact on Oregon Health Plans and Oregon Health Authority Covered Lives

April 25, 2011 Draft

EXECUTIVE SUMMARY

A May 2010 analysis of potential savings from avoided services with the **widespread adoption and use** of health information exchange (HIE) services in Oregon estimates potential savings of $57.7 to $90.7 million per year[1]. The avoided services savings include reductions in laboratory tests, imaging studies, visits and inpatient admissions when patient information is readily available. Recent analyses identified additional savings opportunities of $63.7 to 103.6 million per year related to reduced readmissions by providing discharge plans and information to outpatient and long term care providers, reduced length/complexity of stay for congestive heart failure (CHF), acute myocardial infarction (AMI) and pneumonia patients with access to baseline labs and images, and reduced adverse drug events (ADE) through access to medication and allergy history in inpatient, nursing home and outpatient settings. The total potential savings from both analyses range from $121 to $194 million per year. These potential estimated savings are based on assumptions that some savings are already being achieved and that there is a limit to the level of savings that can be achieved.

As of late 2010, about 3,250,000 lives are covered under various health plan arrangements in Oregon through health insurance plans, managed care organization capitated plans related to Medicaid/OHP, self-insured plans, association and trust plans including some persons covered under more than one plan. Additionally about 300,000 lives are covered by traditional Medicare and about 700,000 Oregonians are uninsured. Potential savings for the 3.2 million lives attributable to the widespread adoption and use of HIE services is about $105 million per year.

As a subset of the 3.2 million lives covered under various health plan arrangements, in early 2011, about 883,000 lives are related to coverage provided under the auspices of the Oregon Health Authority (OHA) through Medicaid/Oregon Health Plan (OHP), Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Potential saving attributable to the widespread adoption and use of HIE services for this subset is about $23 million per year. Reducing or containing the increases in health costs for services under the auspices of OHA is a high priority.

Achieving these savings is critically dependent on the widespread adoption and use of electronic health record (EHR) systems and the ability to move health information

[1] Witter, DM, Health Information Exchange Adoption Impact: Potential Avoidable Service and Productivity Savings from Widespread Adoption, May 2010. Available at http://econ.oregon.gov/OHPPR/HITOC/Documents/ORSavingsPotential.pdf

between EHRs through health information exchange services. While the widespread adoption and use of EHRs and HIE will take a number of years, savings can accrue even in the near term as improvements in EHRs and HIE are implemented.

POTENTIAL SAVINGS ATTRIBUTABLE TO HEALTH INFORMATION EXCHANGE

What are the Savings?

Using savings estimates from national studies applied to the Oregon health care environment, savings projections have been developed that are attributable to the availability of information that is not currently readily available in health care delivery settings about prior medical history, prior laboratory and imaging studies, medications and other health care services. There are other savings opportunities related to the widespread adoption and use of EHRs, clinical decision support and administrative simplification but those savings are not included in the saving estimates related to health information exchange. Table 1 shows projected per member per year (PMPY) savings that could be achieved if information flowed smoothly between provider settings from the widespread adoption and use of health information exchange functionalities. Appendix A and B provide additional information on these PMPY savings estimates.

Table 1. Estimated Per Member Per Year Savings from Widespread HIE Adoption and Use – Mid-Level Savings Estimates

Payer Category	Base Avoided Services Savings PMPY (1)	Other Savings Opportunities PMPY (2)	Total Identified Savings PMPY
Other Plan Payers (3)	$19.54	$22.33	$41.87
Medicare	$38.46	$43.96	$82.42
Medicaid	$10.34	$11.82	$22.16
Kaiser	$1.07	$1.22	$2.29
Uninsured	$5.94	$6.78	$12.72
Overall	**$17.20**	**$19.66**	**$36.86**

(1) Mid-level per member per year savings estimates attributable to HIE functionalities calculated for major payer categories in Oregon savings analysis related to avoided laboratory tests, imaging studies, office visits and inpatient admissions. See Appendix A for additional information.

(2) Mid-level per member per year savings estimates attributable to HIE functionalities estimated by scaling Rhode Island estimates to Oregon base avoided service categories related to reduced readmissions by providing discharge plans and information to outpatient and LTC providers, reduced length/complexity of stay for CHF, AMI and pneumonia patients with access to baseline labs and images, and reduced adverse drug events (ADE) through access to medication and allergy history in inpatient, nursing home and outpatient settings. See Appendix B for additional information.

(3) Other payers Include insurance plans, self-insured plans, association and trust plans as well as VA and some other residual categories.

Who Benefits from the Savings?

The issue of who benefits from avoided services savings is of intense interest to health policy makers, health reformers, employers, health plans, providers and consumers. Ultimately, any reductions in health care delivery costs benefits patients and society as a whole. This analysis considers the potential savings from two different perspectives. First, the analysis estimates the potential savings to health plan organizations. As of

December 2010, the health plan organizations provided coverage for about 3.25 million lives with 2.17 million lives under risk plans and 1.1 million lives in self-insured plans or trusts. Second, the analysis considers the potential savings of the subset of health plan covered lives for coverage under the auspices of the Oregon Health Authority including coverage provided through the Public Employees Benefit Board (PEBB), Oregon Educators Benefit Board and the Oregon Health Plan/Medicaid. As of early 2011, about 883,000 lives are covered under the auspices of the Oregon Health Authority.

When Will the Savings be Realized?

Savings will increase over time with the increased adoption of EHRs, improved interoperability of health information and the adoption of various forms of HIE services. The projected PMPY savings recognize that some HIE improvements have already been realized. The projected savings are based on achieving 80% of possible savings within five years.

For Rhode Island's HIE planning, the Boston Consulting Group estimated that implementation of HIE services would be phased-in over time with 1.7% of the potential savings achieved in year one, 8.3% in year two, 35.0% in year 3, 68.3% in year four and 100% in year five. This phasing seems reasonably consistent with expected roll-out of HIE services in Oregon and potential achievement of savings.

SAVINGS FOR HEALTH PLAN ORGANIZATIONS

Health plan organizations include insurance companies offering health insurance coverage, self-insured health plans offered by employers, health plans provided by trusts and associations, and managed care organizations serving the Oregon Health Plan/Medicaid. A number of organizations have multiple corporate entities offering health plan coverage. Additionally many insurance companies also provide third-party administrative services for self-insured, association and trust plans. Table 2 shows the covered lives for twelve selected organizations that offer one or more health plans and aggregate information on (a) the covered lives in other health plans reporting to the Oregon Department of Consumer and Business Services (DCBS) Insurance Division and (b) covered lives in the Medicaid/Oregon Health Plan that are in smaller managed care organizations or the fee-for-service program. Table 2 distinguishes lives covered under insurance or capitated plans where the organization is directly "at risk" for medical care costs based on premium revenues or capitation versus lives covered by self-insured, trusts or association plans where the plan sponsor is responsible for the medical care costs.

Table 2 shows that 81% of the covered lives for the selected plans involve coverage under premium or capitation arrangements whereas one-third of the total covered lives receive health plan coverage through a self-insured, trust or association plan. Table 2 does overcount the number of covered lives since some family situations involve double coverage and some people have Medicare supplemental coverage in addition to basic Medicare coverage. Additionally, Table 2 does not include the population of uninsured persons of about 700,000.

Table 2. Covered Lives for Selected Health Plan Organizations, December 2010

Selected Health Plan Organizations	Covered Lives in Risk Plans (15)	Covered Lives in Self-Insured and Trust Plans	Total Covered Lives
Regence Plans (1)	277,686	110,733	388,419
Kaiser Plans (2)	323,638	26,597	350,235
Providence (3)	167,881	156,416	324,297
ODS (4)	249,569	39,920	289,489
PacificSource Plans (5)	157,669	28,399	186,068
CareOregon Plans (6)	146,758	0	146,758
Health Net Plans (7)	104,750	9,750	114,500
Mid Valley/Marion-Polk Plans (8)	61,075	2,116	63,191
LifeWise (9)	48,991	6,876	55,867
FamilyCare (10)	47,891	0	47,891
LIPA (11)	42,975	0	42,975
Samaritan Plans (12)	32,738	1,237	33,975
Subtotal	1,661,621	382,044	2,043,665
Other DCBS Plans (13)	367,234	698,463	1,065,697
Other OHP/Medicaid (14)	144,555	0	144,555
Total	2,173,410	1,080,507	3,253,917

Sources: Oregon Department of Consumer and Business Services, Insurance Division, Medical Plan Enrollment Data, 4th Quarter 2010, accessed at http://www.cbs.state.or.us/external/ins/sehi/health-insurance_member-enrollment.html. Oregon Health Plan/Medicaid data for insurance companies not reporting Medicaid enroll from State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Medical Care Delivery System: 15 December 2010 access at http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2010/1210/fchp.pdf.

(1) Regence Plans include Regence BlueCross BlueShield of Oregon and Regence Life and Health Insurance Company.
(2) Kaiser Plans include Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan of the Northwest and Kaiser PCO for Medicaid/Oregon Health Plan lives.
(3) Providence is the Providence Health Plan including Medicaid/Oregon Health Plan lives.
(4) ODS is the ODS Health Plan, Inc.
(5) PacificSource Plans includes PacificSource Community Health Plans, Inc, PacificSource Health Plans, PacificSource Administrators Inc and ClearOne Health Plans (COIHS) for Medicaid/Oregon Health Plan lives.
(6) CareOregon Plans include Health Plan of CareOregon, Inc and CareOregon for Medicaid/Oregon Health Plan lives.
(7) Health Net Plans include Health Net Life Insurance Company and Health Net Health Insurance Plan of Oregon.
(8) Mid Valley/Marion-Polk Plans include MVP Health Authority Employee Benefit Trust, Marion Polk Community Health Plan for Medicaid/Oregon Health Plan lives and Marion Polk Community Health Plan Advantage, Inc.
(9) LifeWise is the LifeWise Health Plan of Oregon.
(10) FamilyCare is the FamilyCare, Inc covering Medicaid/Oregon Health Plan lives.
(11) LIPA is the Lane Individual Practice Association covering Medicaid/Oregon Health Plan lives.
(12) Samaritan Plans include Samaritan Health Plans, Inc, Samaritan Health Services and Intercommunity Health Network for Medicaid/Oregon Health Plan lives.
(13) Other DCBS Plans includes all other insurance companies, trusts and self-insured plans not included above listed reported in the 4th Quarter 2010 report.
(14) Other OHP/Medicaid includes eight managed care organizations not included above plus Primary Care Case Management and Fee-for-Service enrollees.
(15) Includes 226,861 lives in the Medicare Advantage program but does not include lives in traditional Medicare (approximately 300,000 lives) and does not include about 700,000 uninsured persons.

Table 3 shows the potential annual savings to various organizations with the widespread adoption and use of HIE and the avoidance of unnecessary or duplicative services when providers have access to more complete medical history and related clinical information. The Table 3 projections are calculated based the total PMPY savings identified in Table 1 and the types of patients (Medicare, Medicaid or others) in each health plan.

Table 3. Potential Annual Savings for Selected Health Plan Organizations with Widespread HIE Adoption and Use Achieving Avoided Services and Other Savings

Selected Health Plan Organizations	Risk Plan Savings (1) Dollars in 000s	Self-Insured and Trusts Savings (1)	Total Potential Savings
		dollars in 000s	
Regence	$ 12,002.4	$ 4,306.4	$ 16,308.8
Kaiser (2)	1,311.8	92.8	1,404.6
Providence	7,155.7	6,083.0	13,238.7
ODS	9,010.7	1,552.5	10,563.2
PacificSource	5,684.8	1,104.4	6,789.2
CareOregon	2,868.9	-	2,868.9
Health Net	5,133.1	379.2	5,512.3
Mid Valley/Marion-Polk	1,316.5	82.3	1,398.8
LifeWise	1,852.7	267.4	2,120.1
Family Care	824.7	-	824.7
LIPA	740.0	-	740.0
Samaritan	840.3	48.1	888.4
Subtotal	$ 48,741.6	$ 13,916.2	$ 62,657.7
Other DCBS Plans	13,302.5	27,163.2	40,465.8
Other OHP/Medicaid	2,489.2	-	2,489.2
Total	$ 64,533.4	$ 41,079.4	$ 105,612.7

(1) Savings are based on the Table 1 PMPY Total Identified Savings and the related enrollment for each PMPY rate. Saving related to Medicare supplemental coverage are calculated at 20% of the Medicare PMPY savings.

(2) The PMPY saving rates for Kaiser enrollees in Medicaid and Medicare are discounted from the Table 1 savings rates consistent with the relationship between the Table 1 PMPY rate for Other Plan Payers and the Kaiser PMPY.

The Table 3 potential savings totaling $105 million is related to the covered lives in the reporting plans. Potential saving for individuals in out-of-state plans, traditional Medicare services and the uninsured would increase the total potential savings available.

Table 4 shows the projected phase-in of the potential savings from the widespread adoption and use of HIE services based on the Boston Consulting Groups phase-in estimates over five years for the risk plans for selected health plans.

Table 4. Phased Potential Savings for Risk Plans of Selected Health Plan Organizations with Widespread HIE Adoption and Use

Selected Health Plan Organizations	Covered Lives	Year 1 (2011-2012)	Year 2 (2012-2013)	Year 3 (2013-2014)	Year 4 (2014-2015)	Year 5 (2015-2016)
Phase-in of Savings		**1.7%**	**8.3%**	**35.0%**	**86.3%**	**100.0%**
		dollars in 000s				
Regence (3)	277,686	204.0	996.2	4,200.8	8,197.7	12,002.4
Providence (4)	167,881	121.6	593.9	2,504.5	4,887.3	7,155.7
CareOregon (5)	146,758	48.8	238.1	1,004.1	1,959.5	2,868.9
Family Care	47,891	14.0	68.4	288.6	563.3	824.7
Kaiser (6)	323,638	22.3	108.9	459.1	895.9	1,311.8
LifeWise	48,991	31.5	153.8	648.4	1,265.4	1,852.7
LIPA	42,975	12.6	61.4	259.0	505.4	740.0
ODS (7)	249,569	153.2	747.9	3,153.8	6,154.3	9,010.7
Mid Valley/Marion-Polk	61,075	22.4	109.3	460.8	899.2	1,316.5
Health Net (8)	104,750	87.3	426.0	1,796.6	3,505.9	5,133.1
PacificSource	157,669	96.6	471.8	1,989.7	3,882.7	5,684.8
Samaritan	32,738	14.3	69.7	294.1	573.9	840.3
DCBS Residual	367,234	226.1	1,104.1	4,655.9	9,085.6	13,302.5
OHP/Medicaid Residual	144,555	42.3	206.6	871.2	1,700.1	2,489.2
Total	2,173,410	1,097.1	5,356.3	22,586.7	44,076.3	64,533.4

Table 5 shows the projected phase-in of the potential savings from the widespread adoption and use of HIE services based on the Boston Consulting Groups phase-in estimates over five years for the self-insured, association and trusts plans for selected health plans.

Table 5. Phased Potential Savings for Self-Insured and Trust Plans of Selected Health Plan Organizations with Widespread HIE Adoption and Use

Selected Health Plan Organizations	Covered Lives	Year 1 (2011-2012)	Year 2 (2012-2013)	Year 3 (2013-2014)	Year 4 (2014-2015)	Year 5 (2015-2016)
Phase-in of Savings		**1.7%**	**8.3%**	**35.0%**	**86.3%**	**100.0%**
		dollars in 000s				
Regence (3)	110,733	73.2	357.4	1,507.2	2,941.3	4,306.4
Providence (4)	156,416	103.4	504.9	2,129.1	4,154.7	6,083.0
CareOregon (5)	-	-	-	-	-	-
Family Care	-	-	-	-	-	-
Kaiser (6)	26,597	1.6	7.7	32.5	63.4	92.8
LifeWise	6,876	4.5	22.2	93.6	182.6	267.4
LIPA	-	-	-	-	-	-
ODS (7)	39,920	26.4	128.9	543.4	1,060.4	1,552.5
Mid Valley/Marion-Polk	2,116	1.4	6.8	28.8	56.2	82.3
Health Net (8)	9,750	6.4	31.5	132.7	259.0	379.2
PacificSource	28,399	18.8	91.7	386.6	754.3	1,104.4
Samaritan	1,237	0.8	4.0	16.8	32.9	48.1
DCBS Residual	698,463	461.8	2,254.5	9,507.1	18,552.5	27,163.2
OHP/Medicaid Residual	-	-	-	-	-	-
Total	1,080,507	698.4	3,409.6	14,377.8	28,057.2	41,079.4

Table 6 shows the projected phase-in of the potential savings from the widespread adoption and use of HIE services based on the Boston Consulting Groups phase-in estimates over five years for both risk plans and self-insured, association and trusts plans for selected health plans.

Table 6. Phased Potential Savings for Risk Plans of Selected Health Plan Organizations with Widespread HIE Adoption and Use

Selected Health Plan Organizations	Covered Lives	Year 1 (2011-2012)	Year 2 (2012-2013)	Year 3 (2013-2014)	Year 4 (2014-2015)	Year 5 (2015-2016)
Phase-in of Savings		**1.7%**	**8.3%**	**35.0%**	**86.3%**	**100.0%**
		dollars in 000s				
Regence (3)	388,419	277.2	1,353.6	5,708.1	11,138.9	16,308.8
Providence (4)	324,297	225.1	1,098.8	4,633.5	9,042.0	13,238.7
CareOregon (5)	146,758	48.8	238.1	1,004.1	1,959.5	2,868.9
Family Care	47,891	14.0	68.4	288.6	563.3	824.7
Kaiser (6)	350,235	23.9	116.6	491.6	959.3	1,404.6
LifeWise	55,867	36.0	176.0	742.0	1,448.0	2,120.1
LIPA	42,975	12.6	61.4	259.0	505.4	740.0
ODS (7)	289,489	179.6	876.7	3,697.1	7,214.7	10,563.2
Mid Valley/Marion-Polk	63,191	23.8	116.1	489.6	955.4	1,398.8
Health Net (8)	114,500	93.7	457.5	1,929.3	3,764.9	5,512.3
PacificSource	186,068	115.4	563.5	2,376.2	4,637.0	6,789.2
Samaritan	33,975	15.1	73.7	310.9	606.8	888.4
DCBS Residual	1,065,697	687.9	3,358.7	14,163.0	27,638.1	40,465.8
OHP/Medicaid Residual	144,555	42.3	206.6	871.2	1,700.1	2,489.2
Total	3,253,917	1,795.4	8,765.9	36,964.5	72,133.5	105,612.7

SAVINGS FOR OREGON HEALTH AUTHORITY COVERED LIVES

As a subset of the 3.2 million lives covered under various health plan arrangements, in early 2011, about 883,000 lives are related to coverage provided under the auspices of the Oregon Health Authority (OHA) through Medicaid/Oregon Health Plan (OHP), Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB). Potential savings attributable to the widespread adoption and use of HIE services is about $23 million per year. Reducing or containing the increases in health costs for services under the auspices of OHA is a high priority.

Table 7 shows that the potential savings related to the widespread adoption and use of HIE services for the major populations of covered lives under the auspices of the Oregon Health Authority is about $23 million per year.

Table 7. Potential Annual Avoided Services Savings for OHA Covered Lives for the Widespread HIE Adoption and Use

OHA Covered Populations	Covered Lives	Base Avoided Services (2)		Other Savings Opportunities (3)		Total Potential Annual Savings $ in 000s
		Mid-level PMPY Savings (4)	Potential Annual Savings $ in 000s (5)	Mid-level PMPY Savings (6)	Potential Annual Savings $ in 000s (5)	
Kaiser OEBB & PEBB covered lives	42,842					
Estimated portion of Kaiser enrollment stable from year-to-year (7)	90%					
Estimated stable Kaiser enrollment (7)	38,558	$ 1.07	$ 41.3	1.22	$ 47.0	$ 88.3
Kaiser enrollment estimated to move in & out of other health plans	4,284	19.54	83.7	22.33	95.7	179.4
ODS, Providence - OEBB & PEBB	221,948	19.54	4,336.9	22.33	4,956.1	9,293.0
Not enrolled in a medical plan	7,855					
Total OEBB & PEBB	272,645		4,461.8		5,098.8	9,560.6
Medicaid/OHP	609,990	10.34	6,307.3	11.82	7,210.1	13,517.4
Total	**882,635**		**$ 10,769.1**		**$ 12,308.9**	**$ 23,078.0**

Notes:
No adjustment made for dual Medicare-Medicaid eligibles.
Kaiser PCO - Medicaid treated as just Medicaid due to high churn rate for Medicaid generally
(1) OEBB and PEBB covered lives as of February 15, 2011; Medicaid/OHP enrollment as of January 15, 2011
(2) Oregon savings analysis for selected opportunities by Witter & Associates, May 2010. Savings include avoided office visits, laboratory and imaging tests, and reduced emergency room costs attributable to missing information. Report available at http://econ.oregon.gov/OHPPR/HITOC/Documents/ORSavingsPotential.pdf.
(3) Estimated impacts of other savings opportunities identified in Rhode Island analysis by Boston Consulting Group, December 2008. Savings include reduced readmissions by providing discharge plans and information to outpatient and LTC providers, reduced length/complexity of stay for CHF, AMI & pneumonia patients with access to baseline labs and images, and reduced adverse drug events (ADE) through access to medication and allergy history.
(4) Mid-level per member per year savings attributable to HIE functionalities calculated for major payer categories in Oregon savings analysis.
(5) Potential annual savings achievable related to HIE functionalities with widespread EHR and HIE use.
(6) Mid-level estimates of per member per year savings attributable to HIE functionalities estimated by scaling Rhode Island estimates to Oregon base avoided service categories.
(7) Estimated portion of Kaiser enrollment that is stable from year to year. Lower savings are estimated for stable enrollment.

Table 8 shows the phased-in impact of the estimated savings assuming that the deployment of the various types of HIE services is beginning to occur in 2011 consistent with Oregon's HIE Strategic and Operational Plans and developmental efforts occurring around Oregon.

Table 8. Phase-In Impact of Potential Savings for OHA Covered Lives

PHASE-IN IMPACT FOR ESTIMATED SAVINGS					
Oregon Phase-In Impact Using Rhode Island Pre-ARRA Uptake Rates projected by Boston Consulting Group, December 5, 2008 for State Medicaid, Employers (ASO) and Health Plans (Risk)	Fiscal Year	Phase-in of Savings	Base Avoided Services	Other Savings Factors	Total
			dollars in 000s		
	2011-12	1.7%	$ 183.1	$ 209.3	$ 392.3
	2012-13	8.3%	893.8	1,021.6	1,915.5
	2013-14	35.0%	3,769.2	4,308.1	8,077.3
	2014-15	68.3%	7,355.3	8,407.0	15,762.3
	2015-16	100.0%	10,769.1	12,308.9	23,078.0

DISCUSSION AND LIMITATIONS

This analysis was developed to show the potential savings benefits related to avoided services and other savings opportunities related to the widespread adoption and use of HIE services. The analysis considers the savings from reduced health care costs based on plan enrollment and the projected PMPY savings for identified savings opportunities. The analysis estimates savings for twelve selected health plan organizations and shows aggregate results for other health plans of about $105 million per year based on mid-point estimates of savings.

As a subset of the 3.2 million lives in various health plans, the analysis also considers the potential saving associated with covered lives (about 883,000 lives) under the auspices of Oregon Health Authority programs for Medicaid/OHP, PEBB and OEBB. The potential savings opportunity related to the widespread adoption and use of HIE services for the OHA subset of enrollees is about $23 million per year.

Achieving these savings is critically dependent on the widespread adoption and use of electronic health record (EHR) systems and the ability to move health information between EHRs through health information exchange services. While the widespread adoption and use of EHRs and HIE will take a number of years, savings can accrue even in the near term as improvements in EHRs and HIE are implemented. The analysis does not consider

- The full spectrum of savings opportunities related to avoided services but focuses on areas where sufficient data is available for analysis.
- Savings estimates for traditional Medicare enrollees or uninsured persons.
- Productivity impacts on providers and plans for efficiencies with improved information availability through HIE or the productivity impacts of EHR and HIE implementation and operations.
- The role of providers in financing uncompensated care and the savings that would result from avoided services savings with the widespread HIE adoption and use.

Limitations

There are a number of limitations to this analysis that should be considered in interpreting these results. The May 2010 savings analysis report describes a number of limitations in estimating the potential savings that are the basis of this current analysis. Additional limitations related to this analysis include:

- The real potential savings opportunity for specific health plans will be different from the statewide PMPY savings rates used in the analysis and will vary between plans, perhaps significantly.
- The number of double-covered persons is unknown, and likely varies significantly between plans and is not addressed in the analysis.
- The patient/responsible party share of savings is not distinguished from the health plan savings estimates.
- While the analysis focuses on HIE-related savings, the analysis does not address the forms or mechanisms in which HIE may occur, evolving vendor and market HIE solutions, role of local HIE services, role of statewide central core HIE services, impact of the Direct Project or related issues.

APPENDIX A: POTENTIAL AVOIDED SERVICE AND PRODUCTIVITY SAVINGS[2]

The Oregon HIE planning process has included an analysis of the potential state-wide annual savings associated with the widespread use of HIE in Oregon over the next three to five years. The analysis applies national studies to the Oregon environment. Tables A-1 and A-2 show the range of annual savings impacts expected in three to five years with widespread adoption of HIE services across Oregon. Table A-3 shows the potential avoidable services savings on a per member per year basis. A number of other savings opportunities were not considered in the analysis. Table A shows each of the savings components covered by the analysis.

Table A-1: Range of Potential Annual Savings Associated with Widespread Use of HIE Services in Oregon by Savings Category

Estimated Community-wide Savings for Widespread Use of HIE Services in Oregon by Savings Category	Oregon Total (000s)		
SMITH: Avoided Services Ambulatory Care Settings	**Low**	**Med**	**High**
Avoidable Visits Caused by Missing Information	$9,911.2	$9,911.2	$9,911.2
Avoidable Laboratory Tests due to Missing Information	$8,159.4	$8,159.4	
Avoidable Imaging Studies due to Missing Information	$23,980.5	$23,980.5	
SMITH: Avoided Emergency Room Related Services			
Avoidable Admissions Caused by Missing Information	$1,665.8	$1,665.8	$1,665.8
Avoidable Laboratory Tests due to Missing Information	$3,064.0		
Avoidable Imaging Studies due to Missing Information	$8,956.0		
CITL – HIE&I			
Savings from Avoidable Outpatient Imaging Studies			$44,302.9
RAND			
Savings from Avoidable Outpatient Laboratory Tests			$34,813.5
OVERHAGE			
Reduced Emergency Room Costs - Visits Leading to Inpatient Admissions		$12,791.3	
Reduced Emergency Room Costs - Outpatient Visits		$9,237.6	
Total Estimated Avoided Services Savings	**$55,737.0**	**$65,745.9**	**$90,693.3**
PRODUCTIVITY SAVINGS (SMITH)			
Productivity Improvements in Ambulatory Care			
Physician/Staff Productivity Loss Looking for Information	$6,745.2	$6,745.2	$6,745.2
Physician Productivity Impact - Repeated Work	$17,588.4	$17,588.4	$17,588.4
Productivity Improvements in Emergency Room			
Physician/Staff Productivity Loss Looking for Information	$2,500.6	$2,500.6	$2,500.6
Physician Productivity Impact - Repeated Work	$6,457.2	$6,457.2	$6,457.2
Total Estimated Productivity Savings	**$33,331.5**	**$33,331.5**	**$33,331.5**
Total Estimated Savings	**$89,068.5**	**$99,077.3**	**$124,024.8**

The benefits of avoided services accrue to

- health plans that would otherwise pay for services,
- patients for co-insurance and deductibles, and
- providers that provide services to uninsured patients.

[2] From Health Information Exchange Adoption Impact: Potential Avoidable Service and Productivity Savings from Widespread Adoption, May 2010. Available at http://econ.oregon.gov/OHPPR/HITOC/Documents/ORSavingsPotential.pdf

Table A-2 shows distribution of savings by major payer categories.

Table A-2: Estimated Annual Avoided Service Savings by Payer Category

Payer Category	Range of Savings by Payer Category (dollars in 000s)		
	Low	Mid	High
Other Plan Payers (1)	$33,263	$36,477	$54,673
Medicare	$15,711	$20,364	$24,548
Medicaid	$2,922	$4,418	$5,163
Kaiser	$263	$320	$628
Uninsured	$3,578	$4,167	$5,682
Total Estimated Annual Savings	**$55,737**	**$65,746**	**$90,693**

(1) Includes insurance plans and self-insured plans as well as VA and some other residual categories

Table A-3 shows the distribution of savings by major payer categories from Table A-2 on a per member per year (PMPY) basis. These PMPY vary significantly across the payer categories largely due to the different utilization rates of the age demographic categories of the payer categories and the unique characteristics of Kaiser Permanente.

Table A-3: Estimated Annual Avoided Service Savings by Payer Category – Per Member per Year

Payer Category	Range of Savings by Payer Category Per Member per Year (dollars)		
	Low	Mid	High
Other Plan Payers (1)	$17.82	$19.54	$29.28
Medicare	$29.67	$38.46	$46.36
Medicaid	$6.84	$10.34	$12.09
Kaiser	$0.88	$1.07	$2.10
Uninsured	$5.10	$5.94	$8.10
Estimated PMPY Savings	**$14.58**	**$17.20**	**$23.72**

(1) Includes insurance plans and self-insured plans as well as VA and some other residual categories

Other Savings Categories: The savings analysis did not assess other potential savings areas that may substantially increase the impact of HIE services. Some notable areas in which additional savings related to electronic HIE use have been described in the literature that may be applicable include:

- The impact of medication list and history availability, overall prescription drug use, generic substitution, reductions in adverse drug events (ADEs) and reductions in overall medical errors.
- Improved efficiency in medication reconciliation processes in practices, clinics and hospitals.
- Improved management of individuals with an MRSA (or other high cost communicable disease) history or high-risk along with reduced hospital stays and collateral infections.
- Improved public health monitoring and prevention efforts from general health information sharing.

APPENDIX B: OTHER POTENTIAL AVOIDED SERVICE SAVINGS

The analysis summarized in Appendix A covers selected categories of savings opportunities where Oregon data was readily available to make the estimates. As noted in Appendix A, there are other savings opportunities that were not included in the May 2010 analysis.

Similar models to the Oregon analysis have been used in other states to estimate the potential savings from the implementation and use of health information exchange services.

A saving analysis in Rhode Island by Boston Consulting Group in 2008 provides an opportunity to develop estimates for some additional categories of savings for Oregon. The Rhode Island – Boston Consulting Group (RI-BCG) analyses included potential savings estimates for laboratory and imaging studies based on the Center for Information Technology Leadership (CITL) and RAND studies. The underlying methodology and savings parameters for RI-BCG lab and imaging savings estimates are comparable to the methods used in estimating lab and imaging savings in Oregon. The RI-BCG analyses also estimated savings for:

- reduced readmissions by providing discharge plans and information to outpatient and LTC providers,
- reduced length/complexity of stay for CHF, AMI & pneumonia patients with access to baseline labs and images, and
- reduced adverse drug events (ADE) through access to medication and allergy history in inpatient, nursing home and outpatient settings.

Table B-1 shows that the Oregon analysis of avoidable laboratory testing and imaging studies was 53.7% of the amounts estimated in Rhode Island. Applying the 53.7% to the other savings opportunities identified in Rhode Island generates an approximation for the potential saving opportunity in Oregon.

Table B-1: Oregon PMPY Savings based on Other Savings Identified by the Boston Consulting Group for Rhode Island

	Rhode Island – Boston Consulting Group PMPY Savings	Oregon PMPY Saving
Common Savings Analysis between Rhode Island and Oregon		
Avoided duplicative testing: laboratory and imaging studies	$35.15	$18.88 (1) 53.7% of RI-BCG
Imputed Oregon Savings based on Rhode Island Savings		
Reduced readmissions by providing discharge plans and information to outpatient and LTC providers	$19.95	$10.72 (2)
Reduced length/complexity of stay for CHF, AMI & pneumonia patients with access to baseline labs and images	$16.15	$8.67 (2)
Reduced adverse drug events	$3.24	$1.76 (2)

	Rhode Island – Boston Consulting Group PMPY Savings	Oregon PMPY Saving
(ADE) through access to medication and allergy history		
Total for New Categories	$39.34	**$21.15 (2)**

(1) Average of CITL and RAND estimates for Oregon.
(2) 53.7% of the RI-BCG PMPY estimated savings.

The potential savings in Oregon of $21.15 PMPY from the three additional categories represents an average level of savings. To estimate the range of impacts (i.e., low, mid, high) by payer categories comparable to Table A-3, it was necessary to consider the unbalanced distribution of the range of PMPY savings in Table A-3. Table B-2 shows the estimated low, mid and high estimated PMPY savings with consideration of the unbalance distribution. Therefore overall mid PMPY of $19.66 is less than the average of $21.15.

Table B-2: Range of Other PMPY Savings Categories by Payer Category

Payer Category	Range of Savings by Payer Category Per Member per Year (dollars)		
	Low	**Mid**	**High**
Other Plan Payers (1)	$20.38	$22.33	$33.44
Medicare	$33.90	$43.96	$52.95
Medicaid	$7.81	$11.82	$13.82
Kaiser	$1.00	$1.22	$2.41
Uninsured	$5.83	$6.78	$9.24
Estimated PMPY Savings	**$16.66**	**$19.66**	**$27.10**

(1) Includes insurance plans and self-insured plans as well as VA and some other residual categories

Table B-3 shows the total potential savings opportunity for Oregon calculated as the product of the PMPY rates and the Oregon population by payer categories.

Table B-3: Estimated Annual Other Savings by Payer Category

Payer Category	Range of Savings by Payer Category (dollars in 000s)		
	Low	**Mid**	**High**
Other Plan Payers (1)	$38,014	$41,693	$62,437
Medicare	$17,950	$23,277	$28,037
Medicaid	$3,336	$5,048	$5,902
Kaiser	$298	$364	$718
Uninsured	$4,090	$4,757	$6,483
Total Estimated Annual Savings	**$63,689**	**$75,138**	**$103,577**

(1) Includes insurance plans and self-insured plans as well as VA and some other residual categories

Oregon Health Information Technology Oversight Council

Oregon Statewide Health Information Exchange Budget Overview

April, 2011

The latest budget estimates related to the Office of the National Coordinator for Health IT (ONC) Health Information Exchange (HIE) Cooperative Agreement and other activities of the Health Information Technology Oversight Council (HITOC) and the Office of Health Information Technology (OHIT) are summarized in Table 1.

Table 1: Budget Summary

	ONC HIE Cooperative Agreement (4 years)	**2011-13 Biennium portion**
	Feb 2010 - Jan 2014	**Jul 2011 - June 2013**
	$ in Millions	
Oregon HIE & HIT Program Budget	15.52	9.26
Financing Sources		
ONC HIE Cooperative Agreement - Federal Funds	8.58	5.12
Medicaid share of HIE/HIT - Federal Funds	4.75	2.81
General Funds (match for Federal Funds)	0.71	0.38
In-Kind	1.45	0.89
Total Financing Sources	15.49	9.21

Table 2 shows the cost components and financing sources associated with this budget detailed by the four project years of the ONC HIE Cooperative Agreement (Feb. 2010 – Jan. 2015) and each of the years of the 2011-2013 biennium.

The major cost components of HITOC, OHIT, and the ONC Cooperative Agreement are:

- HITOC/OHIT Salary & Fringe: Salary and fringe benefits for employees supporting HITOC, OHIT, and the ONC Cooperative Agreement.
- HITOC/OHIT Other Costs: Services, supplies, consultants/contractors, and travel costs, associated with HITOC, OHIT, and/or the ONC Cooperative Agreement.
- HIE Services Salary & Fringe: Salary and fringe benefits for OHIT staff related to the implementation and operation of the central HIE Core Services (maybe be transferred to SDE).
- HIE Services Other Costs: Services and supplies related to the implementation and operation of the central HIE Core Services (may be transferred to SDE).
- Technology Acquisitions & Services: Cost for acquiring, implementing, and operating the technology services under a Software as a Service (SaaS) model.
- Adoption Pilot & Demonstration Projects – funding: Funding for local pilots and demonstration projects related to HIE services.
- Adoption Pilot & Demonstration Projects – match: Matching amount contributed by participants in local pilots and demonstration projects related to HIE services.

Table 2: Detailed Budget Information

	ONC HIE Cooperative Agreement: February 2010 to January 2014						2011-13 Biennium		
	Proj Yr 1 Feb 2010 - Jan 2011	Proj Yr 2 Feb 2011 - Jan 2012	Proj Yr 3 Feb 2012 - Jan 2013	Proj Yr 4 Feb 2013 - Jan 2014	Total Feb 2010 - Jan 2014		FY Recap 2011-12	FY Recap 2012-13	2011-2013
$ in Millions									
PROGRAM BUDGET - Incurred & In-Kind Costs by Major Components									
HITOC/OHIT Salary & Fringe	0.33	0.66	0.64	0.64	2.28		0.67	0.64	1.31
HITOC/OHIT Other Costs	1.90	3.14	0.93	0.93	6.90		2.06	0.93	2.99
HIE Services Salary & Fringe	-	0.16	0.32	0.32	0.81		0.30	0.32	0.62
HIE Services Other Costs	-	0.06	0.08	0.08	0.21		0.09	0.08	0.16
Technology Acquisitions & Services	-	0.77	1.78	1.77	4.32		1.20	1.97	3.17
Adoption Pilot & Demonstration Projects – funding	-	0.10	0.30	0.10	0.50		0.23	0.28	0.50
Adoption Pilot & Demonstration Projects – match	-	0.10	0.30	0.10	0.50		0.23	0.28	0.50
Total Costs	2.23	4.99	4.35	3.94	15.52		4.77	4.49	9.26
Recap of Incurred vs. In-Kind Costs									
Subtotal Incurred Costs	1.99	4.57	3.86	3.65	14.07		4.35	4.03	8.37
Subtotal In-Kind Costs	0.24	0.43	0.49	0.29	1.45		0.42	0.47	0.89
Total Costs	2.23	4.99	4.35	3.94	15.52		4.77	4.49	9.26
FINANCING SOURCES	**Assuming Funding Parameters from August 17, 2010 Medicaid Directors Letter**								
Medicaid share (39%) - Federal Funds (90%)	0.70	1.54	1.40	1.11	4.75		1.46	1.35	2.81
ONC HIE grant - Federal Funds	1.19	2.79	2.25	2.36	8.58		2.66	2.47	5.12
Oregon General Fund Support	0.15	0.17	0.19	0.19	0.71		0.19	0.19	0.38
Fees & Services Revenues	no current statutory or administrative authority for fees or services charges								
Subtotal Financing for Incurred Costs	2.04	4.50	3.84	3.66	14.04		4.31	4.01	8.32
In-Kind Costs – Contributed Support	0.24	0.43	0.49	0.29	1.45		0.42	0.47	0.89
Total Financing	2.28	4.93	4.33	3.95	15.49		4.73	4.48	9.21
FINANCING SURPLUS OR <SHORTFALL>	0.04	(0.07)	0.02	0.01	(0.03)		(0.04)	(0.02)	(0.06)

Of the $15.52 million total budget for the ONC Cooperative Agreement grant period, $14.07 million represents direct costs incurred, and $1.45 million represents matching in-kind contributions.

The financing sources for HITOC, OHIT, and the ONC Cooperative Agreement are:

- Medicaid Share: Funds from Medicaid's share of HIE and HIT. Medicaid can share in 39% of the HIE and HIT operating costs, with 90% coming from federal funds based on the August 17, 2010 State Medicaid Directors letter.
- ONC HIE Grant Funds: Federal grant funds under the ONC HIE Cooperative Agreement.
- Oregon General Fund Support: State of Oregon General Fund support for HITOC and OHIT; providing funding for the match required for federal funding from Medicaid and the ONC Cooperative Agreement.
- In-Kind Costs: Valuation of the contributed time and effort by volunteers supporting HITOC and its workgroups, as well as matching funds related to local pilot and demonstration projects.

Oregon Health Information Exchange Technology Plan

Krysora, LLC

2011-04-19 DRAFT

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Background and History

The planning effort for statewide Health Information Exchange (HIE) began in earnest in late 2009 upon the approval of the State Health Information Exchange Cooperative Agreement Program from the ONC. Through that planning effort, the mission and goals for HIE in Oregon were established.

> **HIE Mission:**
> *Information, when and where it is needed, to improve health and health care.*

Goals of Health Information Exchange

- To ensure patients have safe, secure access to their personal health information and the ability to share that information with others involved in their care.
- To engage in an open, inclusive, and collaborative public process that supports widespread electronic health record (EHR) adoption and robust, sustainable statewide coverage.
- To improve population health.
- To improve health care outcomes and reduce costs.
- To integrate and synchronize the planning and implementation of HIE and health IT in the public and private sectors, including Medicaid and Medicare provider incentive programs, the Regional Extension Center, local and regional HIOs and other efforts underway.
- To ensure accountability in the expenditure of public funds.

Throughout the planning process, input was gathered through a rigorous process of stakeholder engagement, feedback and review. This technology plan builds upon the principles laid forth in Oregon's HIE Strategic Plan.

HIE/HIT Environment in Oregon

As a recognized leader in health information technology adoption and reform of its health care delivery system, Oregon has a robust foundation upon which to build comprehensive statewide health information exchange (HIE). Supported by the rapid adoption of HIT among Oregon's health systems, hospitals, and ambulatory care providers, a promising opportunity has emerged to advance intra- and interstate HIE. Given Oregon's history as an innovative state for its health reform policies and a recognized national leader for a number of its health IT initiatives, the state was well-positioned when the federal HITECH Act became public law in 2009 as part of the federal stimulus package, the American Reinvestment and Recovery Act (ARRA).

In 2009, an extensive survey of EHR adoption and usage was commissioned by the Office of Oregon Health Policy and Research. This survey included hospitals and health systems, ambulatory care providers, nursing homes and long-term care facilities. The findings of this study revealed that Oregon had a higher rate of EHR adoption than found in other states and that generally, providers had adopted certified technology.

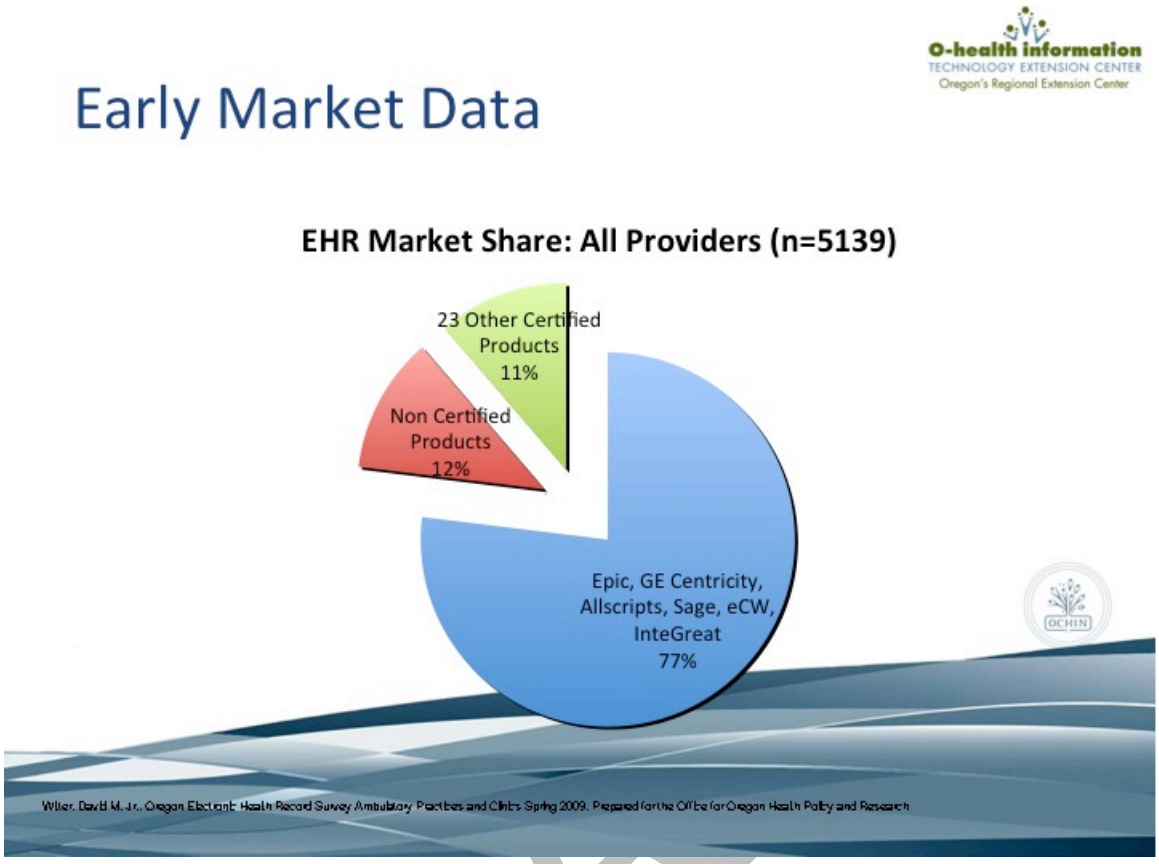
Provider Type	Table 5. Higher Rates of EHR Adoption in Oregon
Acute Care Hospitals	47 of Oregon's 58 acute care hospitals (ACHs) either have or are implementing EHRs by mid-2010, representing 95% of Oregon ACH discharges in 2008.
Critical Access Hospitals	17 of Oregon's 25 critical access hospitals (CAH) operate an EHR, representing 76% of 2008 Oregon CAH discharges.
# of Clinic Sites	Practices with more than one location have higher rates of EHR adoption (range of 40% for two locations to 69% for five or more locations).
Larger Practices	Practices with 50 or more clinicians (79% adoption rate) and practices with 5-9 clinicians (50% adoption rate) have higher rates of EHR adoption.
Specialty Care Providers	Multispecialty and mixed primary care practices have higher EHR adoption rates.

Summary of hospitals and non-hospital providers in Oregon currently using CCHIT-certified EHR vendor/products:

- 81 commercial vendor/product lines in use in Oregon.
- Eight vendor/products are used by 83% of clinicians.
- All 47 Oregon hospitals with EHRs use a range of CCHIT products.
- 81% of practices and clinics with EHRs (88% of clinicians) use a product where one or more versions in the product line have received certification from CCHIT.

As part of HITECH and integral to the success of HIT Adoption and utilization of HIE by a broad base of participants, Oregon's REC, O-HITEC, has been working with providers and providers groups to increase EHR adoption amongst Oregon's eligible providers. In March 2011, O-HITEC provided and update on their program to HITOC. In this update, O-HITEC provided an overview of their progress to-date.

Key points from the March 2011 update that inform this HIE Technology Plan are as follows:



This information was especially illustrative in that it confirmed the information revealed by the 2009 Environmental Scan: wide adoption of EHRs both in number and in vendor product. This information reinforced our need for standardized transport services (HIE Messaging Services) and discoverability of entities and providers using dissimilar technology (Provider Directories).

Meaningful Use Incentive Program

One of the main drivers behind the HIE efforts within Oregon, and other states, is the Meaningful Use initiative. This program was put in place to drive the adoption and meaningful use of EHRs by providers and hospitals who see significant populations of Medicaid and Medicare beneficiaries. As HIE is a key component of the Meaningful Use criteria, the Technology Plan must consider the needs of these providers and hospitals. By adopting standardized services for message transport and provider discovery, and adopting best practices for security, Oregon is providing a mechanism for all eligible providers to qualify for their Meaningful Use payments in the first year (2011).

Oregon's HIO Landscape

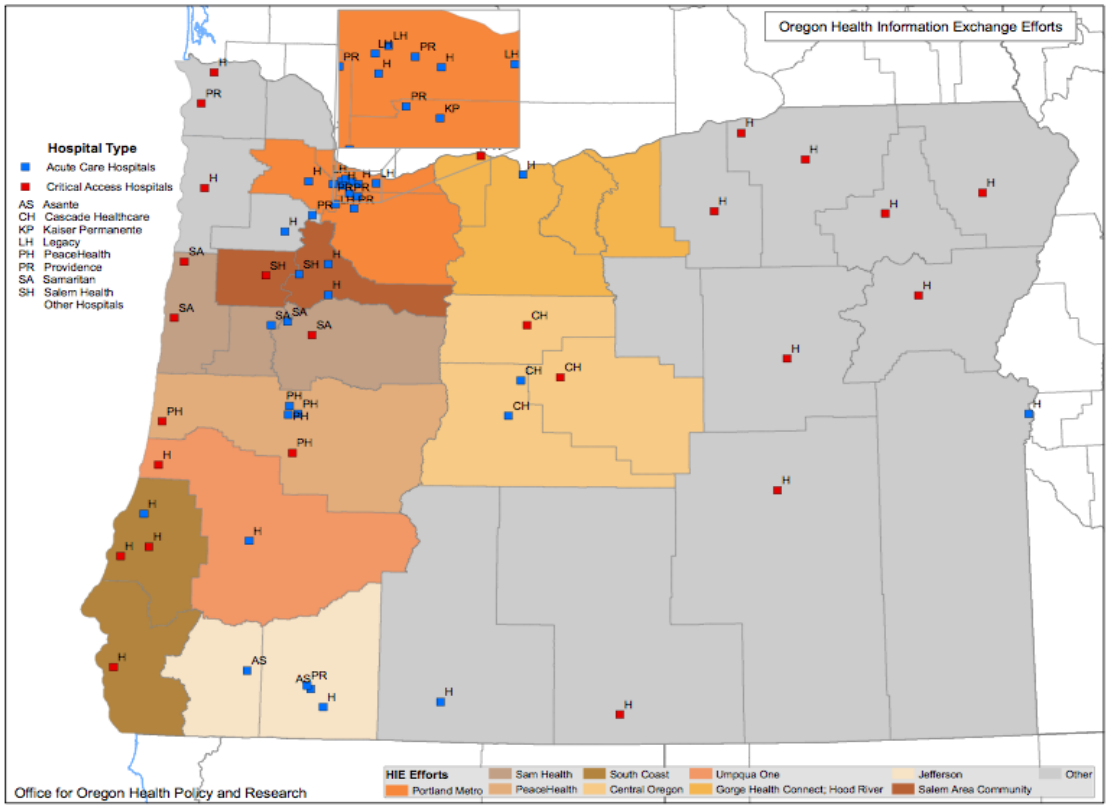
In Oregon, a number of HIO activities are supported by private, non-profit and public sector organizations. As of February 2010, there were several HIOs

considered as operational or soon-to-be operational. Concurrently, there are eight health systems in Oregon currently offering limited HIE services among hospitals, affiliated clinics, and/or providers. These efforts are at different stages of maturity and focus on a range of exchange activities. Although several HIOs are operational and have started to provide value-added services, only a couple of these organizations are close to providing comprehensive exchange services.

As Oregon's providers continue to focus their efforts on achieving meaningful use (MU) objectives, it seems reasonable to anticipate that local HIOs within the state will both increase services and expand geographically, primarily driven by designated medical service area(s). The technologies and exchange connections already in use may serve as models and offer solutions for HIE for other HIOs to build upon. At present, however, only a small percentage of eligible providers in Oregon have access to HIE services offered through a regional or local HIO.

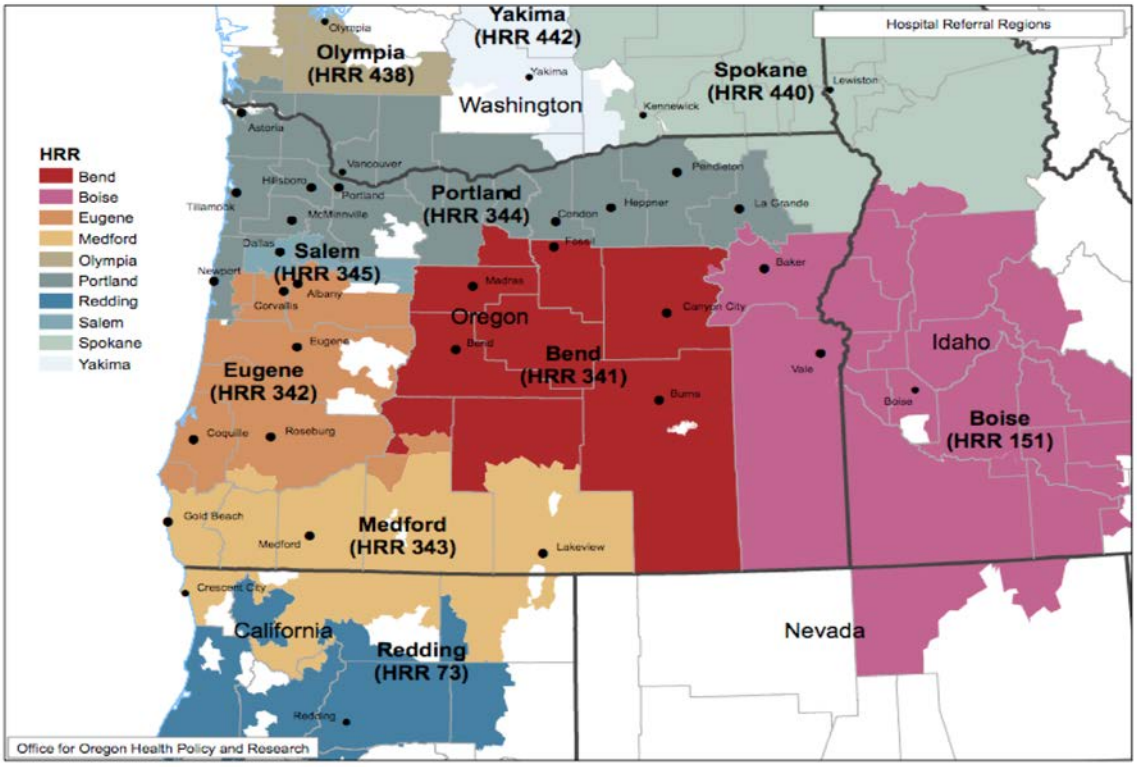
Identified HIO and local HIE efforts are:

- Bay Area Community Health Information Agency (BACIA)
- St. Charles Health System
- Douglas County Independent Practice Association (DCIPA)
- Gorge Connect
- Jefferson HIO
- Northeast Oregon Network (NEON)
- Oregon Community Health Information Network (OCHIN)
- PeaceHealth
- Portland-Vancouver Metro HIE
- Salem Area Community Health Information Exchange (SACHIE)



Interstate HIE

Oregon has significant trading partners and patient referral patterns with its neighbors. In order to ensure proper care coordination of its health care consumers, Oregon's technology plan must include the capability to exchange health information across state lines. With the adoption of national standards and best practices, Oregon is well situated to fulfill the needs of providers both within and outside of its borders.



Emergence of ACOs and Oregon's Health System Transformation

While the exact details of the transformation from a fee-for-service model of health care delivery have yet to be determined, the introduction of ACOs at the national level and the recommendation of a CCO-based model of health care delivery in Oregon do not change our strategy or planned HIE services. ACOs and CCOs are HIE Participants, as defined in our Strategic Plan, just as hospitals, health systems, and providers are today. They will both supply and consume health information as do other HIE participants.

Oregon's HIE Services

Approach from the Strategic Plan

Taking direction from the HITOC Strategic Workgroup, as well as based on wide stakeholder input, Oregon's Strategic plan comprehended a phased approach to services implementation, as well as a prioritization of services within each phase. During Phase 1, the SDE would focus on technology and business services that adhered to nationally recognized standards and processes, and facilitated widespread health information exchange between organizations and providers within the state of Oregon. Medium priority services would be identified as those services that provided opportunistic revenue or those deemed of strategic

importance for meeting future HIE objectives. Further detail regarding these services can be found on pages 33-34 of Oregon's Strategic Plan.

Since the beginning of the discussion around technology services, the concept of indexes (or directories) has been in the forefront of the conversation. Several versions and name for these directories have been used: Master Provider Index, Master Patient Index, HIE Participant Directory, Provider Registry, to name a few. Specifically, the Oregon Strategic Plan mentions the following, Provider Registry and HIE Registry. The intent of these two separate registries was to call out the difference between a registry of those organizations that would participate in HIE and an individual health care provider that would participate in HIE.

As part of this initial discussion of technology services to be offered by the SDE, it was recognized that services to insure the security and fidelity of the information to be exchanged were necessary. These Trust Services are necessary for HIE at the local and statewide levels.

Additional services that would provide opportunistic revenue or that provided strategic advantages for future goals were recognized as a Record Locator Service, Patient Lookup Service, bi-direction Public health reporting and alerting capability, quality reporting, and a mechanism for patient/consumer access, such as a service to connect with consumer data repositories. Further detail regarding these services can be found on pages 49-50 of Oregon's Strategic Plan.

Finally, as directed by ONC HIE PIN-001 a mechanism for every provider, regardless of practice size, location, and affiliation, are required to have at least option in place for participating in HIE as part of the Stage 1 Meaningful Use criteria. Additionally, the direction from the ONC strongly recommended that Oregon (and all states and territories) provide additional information as to how they were going to address certain aspects of the Direct Project. To this end, the Strategic Workgroup recommended, with additional support provided by the Technology and Finance Workgroups, that Push Services be included in the core set of services to be offered by the SDE. These services will include the capability for any provider to send a message containing health care information to any other provider for their reference and use in a clinical or administrative encounter.

As our planning process have proceeded and adapted to the changing health care environment, Oregon has settled on three core HIE services to comprise its initial offering: Trust Services, Provider Directories (formerly known as HIE Participant Directory and Provider Registry), and Messaging Services (formerly known as Push Services).

Trust Services

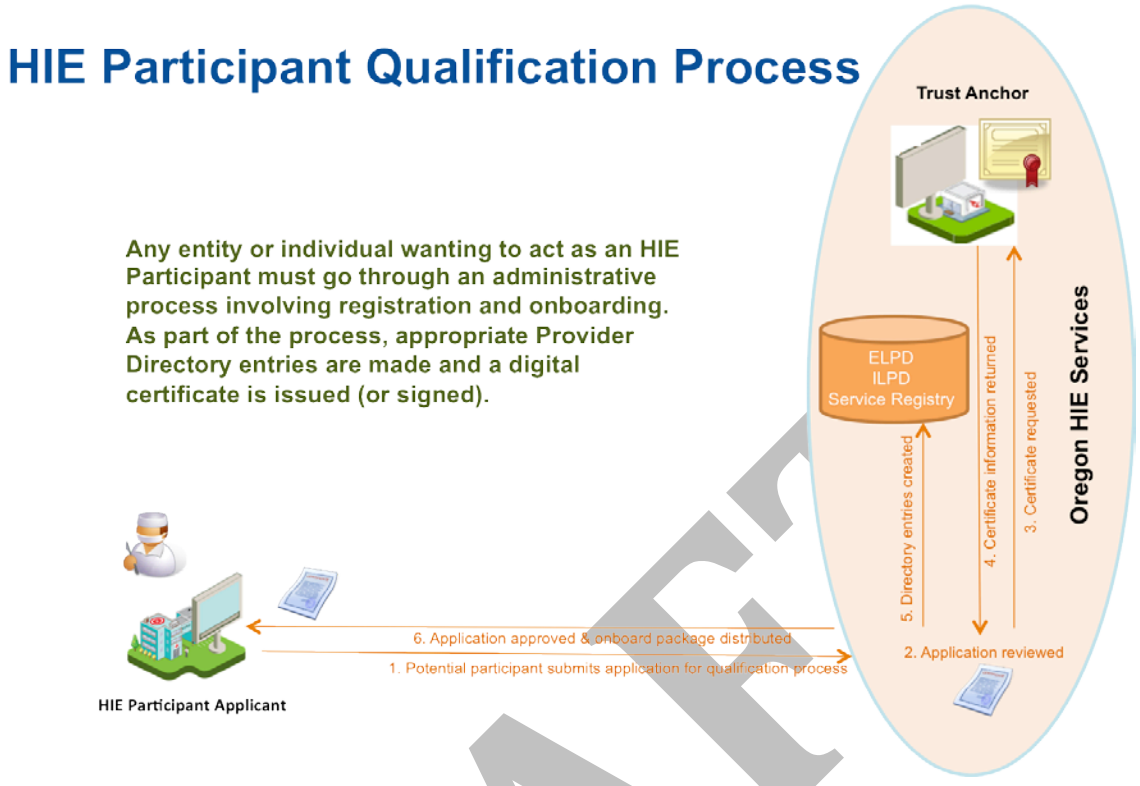
Trust Services provide the necessary framework and controls for secure information exchange. Trust Services not only include the technology necessary to

issue and manage X.509v3 digital certificates, but also include business processes to support the issuance and management of said certificates.

As such, Oregon is in the process of defining an HIE Participant Qualification Program. This program is designed to ensure that all entities providing or facilitating exchange services and participating in statewide exchange (i.e. utilizing the HIE services provided by the state or State Designated Entity (SDE)) are held to the same standards in terms of protecting the privacy and security of protected health information (PHI). The HIPAA Security Rule specifies that entities must develop policies and procedures to protect the confidentiality, integrity, and availability of electronic PHI, but does not specify what those policies and procedures should be, nor does it have any systematic monitoring mechanisms in place to ensure that entities do, in fact, have the appropriate policies and procedures in place. Through Oregon's HIE Participant Qualification Program, mechanisms for affirmatively validating the existence and appropriateness of these policies and procedures, and for enforcing them when entities are found to be non-compliant, will be established.

A second driver behind the HIE Participant Qualification Program is to ensure interoperability and participation in statewide HIE. Oregon's approach to statewide exchange is a federated model, which relies to a great extent on the HIE activities and efforts of the local health information exchange organizations (HIOs). For statewide HIE to thrive in Oregon, the local HIOs will not only need to facilitate exchange among their membership, they will also need to communicate with one another, and with the State/State Designated Entity (SDE), which will provide statewide HIE services to facilitate this HIO-to-HIO exchange. Oregon's Qualification Program will serve to ensure that the necessary technical standards, policies, and procedures are in place to facilitate exchange between HIOs and with the State/SDE. While this program is not a technology-based service, per-se, the Trust Services provided to Oregon HIE Participants must enable tracking of qualified participants, such that PHI is not disclosed to unqualified parties.

The service or suite of services can be contracted out or leased from a vendor or provided by a systems integrator as Software-as-a-Service, including the necessary capability required for an X.509v3-based Certificate Authority to support Direct Project Trust Anchor services, as defined in the *Direct Project Security Overview* (http://wiki.directproject.org/Direct+Project+Security+Overview) and comply with the *Applicability Statement for Secure Health Transport* (http://wiki.directproject.org/Applicability+Statement+for+Secure+Health+Transport) would be an ideal offering. Preferably, Oregon would approve and sign issued certificates, but would not actually create and issue the certificates itself.



Health Information Provider Directories

During the development of the Strategic and Operational Plans, Oregon made a commitment to following the guidance from the federal level and offering solutions that adhered to this guidance and identified standards. Oregon has been following with great interest the work of the ONC's Provider Directory Task Force. Out of this task force, two types of Provider Directories were identified: an Entity-level Provider Directory (ELPD) and an Individual-level Provider Directory (ILPD). In general, the directories should be centralized and allow for the authentication and validation of healthcare providers to exchange health information. The provider directory will facilitate direct messaging to and amongst healthcare providers (NwHIN Direct Project, see Messaging Services).

Entity-level Provider Directory (ELPD)

The ELPD will support the following (at a minimum):

Key Functionality, in support of directed exchanges, both send/receive (i.e., Direct Project) and query/retrieve (i.e., NHIN Exchange) exchanges:

- Basic "discoverability" of an entity
- Basic "discoverability" of an entity's information exchange capabilities
- Basic "discoverability" of an entity's security credentials (e.g., X.509v3 digital certificate)

- The directory should also support the ability for a given entity to review (and possibly modify) "their" information

Information Stored for an Entity:

- Demographics, such as legal entity name, other familiar names, physical address, and human contact
- Relevant domains and website locations
- Supported protocols and standards for information exchange services or pointers to those data
- Security credentials (e.g., X.509v3 digital certificate) or pointers to those credentials

Entities to be included in this directory are:

- Health care provider organizations (i.e., hospitals, clinics, nursing homes, pharmacies, labs, etc)
- Other health care organizations (i.e., health plans, public health agencies)
- Health Information Organizations (i.e., regional HIE operators, health information service providers)
- Other organizations involved in the exchange of health information (business associates, clearinghouses)

For this service we estimate a range of 200 – 5000 entities will be listed in the directory.

Individual-level Provider Directory (ILPD)

Much like the ELPD, the ILPD will be used in support of HIE Messaging Services. The ILPD differs in scope from the ELPD in that the ILPD will contain the information about an individual participant, not an organization.

1. Individual health information providers, not entities or organizations should be listed in the ILPD. The individual provider types listed in the ILPD should conform to federal and state rules on who is licensed or otherwise authorized to provide health care services or individuals authorized to consume health information, e.g., public health workers
2. Information needed for an individual provider listed in the ILPD should include:
   - *Demographics*: Last and first name, provider type, specialty, name and address of practicing locations, practice telephone number, e-mail address and hospital affiliation
   - *Potentially sensitive identifiers*: NPI, DEA, State License #, etc.
3. There should be limited access to and tight policies regarding access to potentially sensitive identifiers (such as state license numbers, DEA numbers, etc.) to minimize the risk of fraud and identity theft.

From a functional perspective, the ILPD should support the following (at a minimum):

1. Support directed exchanges functions (send/receive as well as query/retrieve)
2. Provide basic "discoverability" of and individual provider and their practice location(s). The service should support querying capability at multiple levels (practice location, provider name, specialty, etc.)
3. Provide both basic "discoverability" and tight linkage to an individual provider's ELPD listing
4. Support audit trail capabilities

From an operational perspective, the ILPD provider/operator should supply:

1. Establish defined policies and procedures and provide a structured and secure mechanism for individual providers to enroll and verify information used to populate the ILPD
2. Establish policies and procedures to verify, as appropriate, the information provided by individuals enrolling in the ILPD
3. Data elements included should at least meet the minimum data set recommended by ONC (per recommendations from the HIT Policy and Standards Committee); data elements should follow national standards definitions for content
4. Establish policies and procedures that define who can access and use the ILPD
5. Ensure that the ILPD is able to interoperate with other ILPDs developed and operated in a manner that follow these recommended standards
6. Provide a mechanism for individuals listed in the ILPD or their delegated authority (for instance staff or entity administrators supporting providers who practice in their institution) to correct/update listed information. An update and resolution process and change-control policies should be put into place by ILPD operators to manage a change request process
7. Establish policies that require individuals listed in the ILPD to update periodically their information (at least three times per year) or as individual provider changes practice locations and affiliations
8. Develop and put into place audit trail policies and procedures to track use, and investigate inappropriate use and breaches
9. Develop procedures and a set of policies to link and update a provider's ILPD listing(s) with their affiliated ELPD listing(s).
10. Ensure that each ILPD entry has at least one valid ELPD entry associated with it (there might be more than one ELPD entry associated with each ILPD entry)
11. Establish appropriate linkages between the ILPD and ELPDs to allow interactive access to information about the entities associated with individual providers listed in the ILPD.

12. Implement security policies and procedures that ensures that a) data contained in the ILPD is appropriately protected from unauthorized changes; b) authorized individuals have access to the data for purposes of updates/changes; and c) access to information contained in the ILPD by external users is appropriately managed

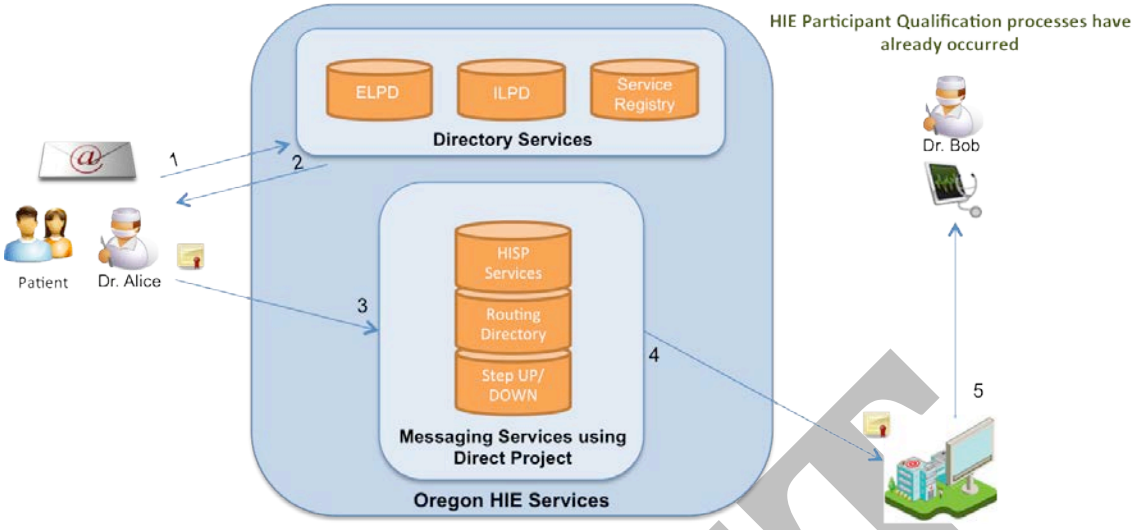
We estimate approximately 50,000 individuals will be listed in the directory.

The ILPD Provider/operator and the State may choose to divide the responsibilities for certain items above, based on vendor offerings, State needs, and supporting processes necessary for HIE. – This is highly dependent on the qualification process.

Population of these directories will occur via the HIE Participant Qualification and Enrollment Process. We do not contemplate using other data sources, directories, or data feeds for Phase One of the HIE Services. As part of planning for Phase Two services, we will analyze the needs of other related programs (such as HIX), using other provider directories and data sources within the state as "feeds" for the provider directories (e.g. MMIS), and the effort necessary to integrate multiple directories into a comprehensive provider directory for the State. Many factors will play into this analysis including the complexity and effort necessary for ETL, deduplication, data importation and mapping from existing data sources.

During Phase One, the ELPD and ILPD will be the two directories used for the purposes of conducting HIE. These directories will be included in the RFP for HIE Services to be issued by the State of Oregon. We expect that these directories will be offered by the vendor or systems integrator as Software-as-a-Service. During the RFP development and assessment, the solution will be reviewed and analyzed in order to select the solution that most effectively utilizes limited resources, time and budget. The extensibility, reusability, and flexibility of the selected solution will be one of many factors included in the assessment of the solution.

The policies necessary to support the operational requirements of the directories will be established, documented, and agreed to via the HIE Participant Qualification Program.



1) Dr. Alice requests Dr. Bob's information from the ILPD, ELPD, and Service Registry.

2) The ILPD, ELPD, and Service Registry return requested information about Dr. Bob.

3) Using the information returned from the ILPD, ELPD, and Service Registry, Dr. Alice sends PHI to Dr. Bob, routed via Messaging Services, uses Trust Services to encrypt message

4) The hospital where Dr. Bob practices receives PHI from Dr. Alice, routed via Messaging Services, uses Trust Services to unencrypt message

5) Hospital routes PHI to Dr. Bob

HIE Messaging Services using the Direct Project

Per guidance from the ONC, each state must offer all providers at least one option for exchanging health information across unaffiliated organizations. Oregon will be offering secure messaging services based on the Direct Project specifications to any and all providers, regardless of their eligibility for Meaningful Use incentives or their participation in HIOs or ACOs/CCOs. The Direct Project provides a lightweight method for transport of health information and allows providers, organizations and market participants the ability to select the best solutions for managing health information for their patients, while supplying the necessary mechanisms for sharing that information with other qualified participants; see http://wiki.directproject.org/file/view/DirectProjectOverview.pdf for an overview of the Direct Project.

Oregon's secure messaging services will be offered as Direct Project HISP (Health Information Service Provider) services. HISP services supported will include digital certificate discovery, routing, and transport of messages. These services will comply with Direct Project specifications for Secure Health Transport. The Direct Project's *Applicability Statement for Secure Health Transport* (http://wiki.directproject.org/Applicability+Statement+for+Secure+Health+Transport) details these specifications, which are based on SMTP, S/MIME, and X.509v3.

In addition to the base Secure Health Transport specifications, HISP services will include interoperability with IHE-based (Integrating the Healthcare Enterprise)

statewide HIE participants. Such interoperability will be via Direct Project specifications for XD* Conversion (also known as "step-up/ step-down"). The Direct Project's *XDR and XDM for Direct Messaging* (http://wiki.directproject.org/XDR+and+XDM+for+Direct+Messaging) details the necessary standards and specifications.

While it's anticipated that most statewide HIE participants will interact with HISP services using their certified EHRs, due to the disparity of technology adoption amongst Oregon providers and EHR vendor upgrade schedules, the HISP will offer a web portal for use by HIE participants to supply the minimal necessary functionality for any health information provider to participate in HIE using its Messaging Services.

Direct Project HISP-related services will be included in the RFP for HIE Services to be issued by the State of Oregon. It is contemplated that this service will be offered by the vendor or systems integrator as Software-as-a-Service. During the RFP development and assessment, the solution will be reviewed and analyzed in order to select the solution that most effectively utilizes limited resources, time and budget.

House Bill 3650

Sponsored by JOINT SPECIAL COMMITTEE ON HEALTH CARE TRANSFORMATION

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Establishes Oregon Integrated and Coordinated Health Care Delivery System to replace managed care systems for recipients of medical assistance. Specifies criteria for coordinated care organizations. Requires Oregon Health Authority to seek federal approval to allow enrollment of individuals who are dually eligible for Medicare and Medicaid into coordinated care organizations. Requires authority to establish alternate payment methodologies for coordinated care organizations. Requires coordinated care organizations to report outcome and quality measures developed by authority. Requires coordinated care organizations to use patient centered primary care homes to extent practicable. Establishes consumer protections for members of and providers in coordinated care organizations. Allows sharing of confidential information within coordinated care organization. Creates exemption from antitrust laws for activities under Oregon Integrated and Coordinated Health Care Delivery System.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health; creating new provisions; amending ORS 192.493, 410.604, 410.612, 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, 414.706, 414.707, 414.712, 414.725, 414.727, 414.728, 414.737, 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, and sections 1 and 9, chapter 867, Oregon Laws 2009; repealing ORS 414.610, 414.630, 414.640, 414.705, 414.727, 414.728, 414.736, 414.738, 414.739, 414.740, 414.741 and 414.742; and declaring an emergency.

Whereas 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; and

Whereas the Oregon Health Plan is a national model addressing the needs of hundreds of thousands of Oregonians; and

Whereas the Oregon Health Plan has improved access for Oregonians in need of health services; and

Whereas the Oregon Health Plan has reduced costs within the delivery system benefiting all Oregonians; and

Whereas managing care and addressing needs outside the Emergency Department has proven beneficial; and

Whereas attention to the development and training of a diverse workforce is critically important to the evolution of service delivery; and

Whereas there is a need and an opportunity to adjust the Oregon model, utilizing and building upon its most effective component, in order to transform the delivery of care incrementally with compassion and coordination; and

Whereas the goal is to build for the future by maximizing resources and ensuring care based on community needs; and

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Whereas county governments have a significant stake and role to play to ensure that this transition does not leave those most in need unserved; and

Whereas uncompensated care is a critical issue to the hospital systems and those they serve; and

Whereas maintaining the continuity of care for patients is of the highest priority; and

Whereas the long term goals of the state are to improve the lifelong health of Oregonians, improve the individual's experience of care and reduce per capita costs; and

Whereas this 2011 Act will consolidate and coordinate the mental and behavioral health care delivery systems with existing managed care delivery physical health systems in conjunction with dental and long term care systems in a manner that reflects community needs and existing county service delivery to these critical populations; now, therefore,

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)*] **(1)** 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.

(2) 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) Individuals who are fully 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.

(3) 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;

(b) Ensure that wages and benefits are at a level that reduce turnover and hence increase experience and quality of care; and

(c) Provide an opportunity for front-line care providers to have a voice in their workplace in order to effectively advocate for quality care.

(4) As used in subsection (2) 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, seniors, people with disabilities, people using mental health services, 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) Results of evaluations;

(c) Rules adopted;

(d) Customer satisfaction;

(e) Coordinated care organization models of care;

(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 15 of this 2011 Act are added to and made a part of ORS chapter 414.

SECTION 4. Coordinated care organizations. 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. A coordinated care organization may be a local, community-based organization or a statewide organization with community-based participation in governance, and 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 ensure that:

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

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

(3) 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.

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

(5) 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 community health workers and personal health navigators.

(6) Services and supports are geographically located as close to where members reside as possible and offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(7) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care.

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

(9) Each coordinated care organization has a formal contractual relationship with the mental health and public health authorities in the counties where the members of the organization reside, which may include a role in governance.

(10) Each coordinated care organization has a governance structure that includes consumers and that reflects:

(a) The responsibility of the organization for risk;

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

(c) The community at large, including the ethnic diversity of the community, seniors, people with disabilities, consumers of mental health services and other consumers, to ensure that the organization's decision-making is consistent with the values of the members and the community.

(11) Each coordinated care organization convenes a community advisory council, which includes representatives of the community and of county government, that meets regularly to ensure that the health care needs of the consumers and the community are being addressed.

(12) 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.

(13) 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 objective quality information and are removed if the providers fail to meet objective quality standards.

(14) Each coordinated care organization reports on outcome and quality measures identified by the authority under section 9 of this 2011 Act and participates in the health care data reporting system established in ORS 442.464 and 442.466.

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

(16) Each coordinated care organization participates in the learning collaborative described in ORS 442.210 (3).

(17) Each coordinated care organization that serves members who are dually eligible for Medicare and Medicaid meets the requirements for an accountable care organization prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 1395jjj.

SECTION 5. Alternative payment methodologies. (1) The Oregon Health Authority shall establish alternative payment methodologies, including global budgets, 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 not reimburse claims for services necessitated by serious adverse events or never events that were within the control of the provider or organization presenting the claim. The authority shall prescribe by rule events constituting "never events" or "serious adverse events" consistent with the standards adopted by the Centers for Medicare and Medicaid Services.

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 must encourage 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 cooperative 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 subsection (2) of this section, coordinated care organizations that meet the criteria adopted under section 4 of this 2011 Act and that serve Medicaid recipients are responsible for providing covered Medicare and Medicaid services to members who are dually eligible for Medicare and Medicaid.

(2) The authority shall apply to the Centers for Medicare and Medicaid Services for approval of contracting procedures and blended reimbursement methods for coordinated care organizations responsible for members who are dually eligible for Medicare and Medicaid. Such procedures and methods shall maintain the rights and benefits of Medicare beneficiaries under Title XVIII of the Social Security Act.

(3) Dually eligible individuals shall be permitted to enroll in and remain enrolled in a program of all-inclusive care for the elderly, as defined in 42 C.F.R. part 460.

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) And the member's family should receive timely, complete, and accurate information in order to effectively participate in care and decision-making and to have consumer and family knowledge, values, beliefs and cultural backgrounds respected in the planning and delivery of care.

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

(d) Must have access to competent 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.

(e) 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.

(f) 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.

(g) Who is dually eligible for Medicare and Medicaid shall have the right to disenroll from a coordinated care organization that fails to promptly provide adequate services or fails to meet service standards and:

(A) To enroll in another coordinated care organization; or

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

(2) 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.

(3) A provider may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the provider is necessary for the organization to qualify as a coordinated care organization. Any disputes arising from a refusal to contract shall be resolved by an independent third party arbitrator in a binding arbitration process prescribed by the authority.

(4) The authority shall:

(a) Monitor and enforce consumer rights and protections within the implementation of restructured health care payment and delivery system changes 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. 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, behavioral health care, 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. In addition to quality measures, the information published must include, but is not limited to:

(a) Costs;

(b) Outcomes; and

(c) Other information necessary to evaluate the value of health services delivered by a coordinated care organization.

SECTION 10. Standards for health care aides. The Oregon Health Authority shall adopt competency and quality measures for community health workers, personal health navigators, peer wellness specialists and other health care workers that are not presently regulated or certified by this state, subject to receipt of federal approvals if necessary.

SECTION 11. 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 and its provider network 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 sections 4, 5, 6, 7, 8 or 9 of this 2011 Act remain 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 12. Transitional provisions. (1) The speed and pace of the transition to the Oregon Integrated and Coordinated Health Care Delivery System will be determined by the availability state resources to fund the system.

(2) The Oregon Health Authority shall develop qualification criteria for coordinated care organizations. The authority shall present the qualification criteria to the appropriate interim committees of the Legislative Assembly no later than October 3, 2011.

(3) The authority shall develop a global budgeting process. The authority shall present the process to the Legislative Assembly for approval by _____. Until a global budgeting process is approved by the Legislative Assembly, the authority shall calculate the reimbursement for health services using the following process:

(a) The authority shall retain an independent actuary that is approved by a majority of the coordinated care organizations contracting with the authority to determine a benchmark global budget that is sufficient to reimburse prepaid managed care health services organizations and fee-for-service providers for the cost of providing health services under ORS 414.705 to 414.750.

(b) The actuary retained by the authority under paragraph (a) of this subsection shall use the following information to determine the benchmark global budget:

(A) For hospital services, the most recently available Medicare cost reports for Oregon hospitals;

(B) For primary care services of physicians licensed under ORS chapter 677 and nurse practitioners certified under ORS chapter 678, 150 percent of the Medicare maximum allowable charge;

(C) For specialty care and other health professionals using procedure codes, the Medicare Resource Based Relative Value Scale conversion rates for Oregon;

(D) For prescription drugs, the most recent payment methodologies in the fee-for-service payment system for the state medical assistance program;

(E) For durable medical equipment and supplies, 80 percent of the Medicare allowable charge for purchases and rentals;

(F) For dental services, the most recent payment rates obtained from dental care organization encounter data; and

(G) For all other services not listed in subparagraphs (A) to (F) of this paragraph:

(i) The Medicare maximum allowable charge, if available; or

(ii) The most recent payment rates obtained from the data available under paragraph (c) of this subsection.

(c) The actuary retained by the authority under paragraph (a) of this subsection shall use the most current encounter data and the most current fee-for-service data that is

available, reasonable trends for utilization and cost changes to the midpoint of the next biennium, appropriate differences in utilization and cost based on geography, state and federal mandates and other factors that, in the professional judgment of the actuary, are relevant to the fair and reasonable estimation of costs. The authority shall provide the actuary with the data and information in the possession of the authority or contractors of the authority reasonably necessary to develop a benchmark global budget.

(d) The authority shall report the benchmark global budget developed under this subsection to the Legislative Fiscal Officer no later than August 1 of every even-numbered year.

(e) The authority shall retain an actuary to determine global budgets for each coordinated care organization that the authority shall use to develop the authority's proposed biennial budget.

(f) The global budget for each coordinated care organization established under paragraph (e) of this subsection must contain a nine percent allowance for administrative expenses and a three percent allowance in net revenue to ensure financial solvency and capitalization.

(g) If the global budgets determined under paragraph (e) of this subsection are inconsistent with the benchmark global budget determined under paragraphs (a) to (c) of this subsection, the authority shall retain the actuary retained to determine the benchmark global budget to evaluate the actuarial soundness of the global budgets determined by the authority under paragraph (e) of this subsection.

(h) The authority shall submit to the Legislative Assembly no later than February 1 of every odd-numbered year the global budgets determined under paragraph (e) of this subsection accompanied by:

(A) Any reports produced by an actuary in accordance with paragraph (g) of this subsection; and

(B) A report comparing the global budgets on which the proposed budget of the authority is based with the benchmark global budget developed by the actuary under paragraphs (a) to (c) of this subsection. If the budgets differ, the authority shall disclose, by the categories described in paragraph (b) of this subsection, the amount of and reason for each variance.

(4) The authority shall amend contracts that are in place on the effective date of this 2011 Act to allow prepaid managed care organizations that meet the criteria developed under subsection (2) of this section to become coordinated care organizations.

(5) In order to allow a period of transition for prepaid managed care health services organizations, the authority shall:

(a) Continue to renew until January 1, 2014, the contracts of dental care organizations that contract with the authority on the effective date of this 2011 Act.

(b) Require coordinated care organizations to reimburse rural hospitals, as defined in ORS 442.470, in accordance with ORS 414.727 and 414.728. The authority shall retain an independent actuary to review the viability of rural hospital participation in the coordinated care organization service delivery model.

SECTION 13. 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 15 of this 2011 Act.

SECTION 14. 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 15 of this 2011 Act. The authority may seek necessary federal approval, including but not limited to:

(a) Federal approval necessary to participate with Medicare in Oregon's alternative payment and coordinated health care and service methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the authority shall seek extensions or additional approvals as necessary. 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.

(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 necessary 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 after receipt of the necessary federal approval and may provide for implementation in stages in accordance with the availability of funding.

SECTION 15. 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 pro-

viders 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 or other health service corporations, 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) The authority shall ensure that any survey or meeting under subsection (4) of this section does not solicit, share or discuss pricing information. Any such survey conducted or meeting held pursuant to this section shall not be a violation of state antitrust laws, and shall be considered state action for purposes of federal antitrust laws through the state action doctrine.

SECTION 16. 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 (3).

(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 17. 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;

(C) Payments based on episodes; and

(D) Payments based on a global budgeting system.

[*(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 op-

tionally 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 promotes health or nutrition within the community in which the individual resides, by:

(a) Serving as a liaison between communities, individuals and coordinated care organizations;

(b) Providing health or nutrition guidance and social assistance to community residents;

(c) Enhancing community residents' ability to effectively communicate with health care providers;

(d) Providing culturally and linguistically appropriate health or nutrition education;

(e) Advocating for individual and community health;

(f) Conducting home visitations to monitor health needs and reinforce treatment regimens;

(g) Identifying and resolving issues that create barriers to care for specific individuals;

(h) Providing referral and follow-up services or otherwise coordinating health and social service options; and

(i) Proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs.

(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 that an individual is eligible for medical assistance under 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 an alternative payment methodology meeting criteria established by the authority in accordance with section 5 of this 2011 Act.

(8) "Health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

(a) Services required by federal law to be included in the state's medical assistance pro-

gram 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 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) "Quality measure" means the measures and benchmarks identified by the authority in accordance with section 9 of this 2011 Act.

(15) "Person centered care" means _____.

(16) "Peer wellness specialist" means _____.

(17) "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.

[*(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 18. 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 19. ORS 414.065 is amended to read:

414.065. **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 **or alternative payment methodologies** to which public assistance funds will be applied toward meeting the costs of providing [*medical and remedial*] **health** care and 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.*]

SECTION 20. 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 recruit, train and certify community health workers and personal health navigators who shall work as part of a multi-disciplinary team under the direction of a licensed or certified health care professional.

(5) If a coordinated care organization chooses to provide the services of a community health worker or a personal health navigator, as those terms are defined in ORS 414.025, the organization shall contract with the commission for the services, under terms of employment established by the commission and subject to the availability of workers and navigators.

[*(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" and "personal health navigator" have the meanings given those terms in ORS 414.025.

SECTION 21. ORS 410.612 is amended to read:

410.612. **Collective bargaining.** (1) For purposes of collective bargaining under ORS 243.650 to 243.782, the Home Care Commission is the employer of record for home care workers**, community health workers and personal health navigators**.

(2) Notwithstanding subsection (1) of this section, home care workers**, community health workers and personal health navigators** may not be considered for any purposes to be [*an employee*] **employees** of the State of Oregon, an area agency or other public agency.

(3) The Oregon Department of Administrative Services shall represent the commission in collective bargaining negotiations with the certified or recognized exclusive representatives of all appropriate bargaining units of home care workers**, community health workers and personal health navigators**. The department is authorized to agree to terms and conditions of collective bargaining agreements on behalf of the commission and the Department of Human Services.

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

SECTION 22. 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*] **by requiring contracts between coordinated care organizations and counties for the following services, if offered by the county:**

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

(b) Case management of residential services for adults and children;

(c) Management of the mental health crisis system;

(d) Management of community-based specialized services such as supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and intensive home-based services for children; and

(e) Global payments to establish patient centered primary care homes within community mental health programs for severely mentally ill adults.

SECTION 23. 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 24. 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*]**, behavioral and oral health 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 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 in writing within 30 days of enrollment with the coordinated care organization about available providers and 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) 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) 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 25. 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) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency 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.

(2) Subsection (1) of this section does 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) 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) 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.

SECTION 26. 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. **Required enrollment in coordinated care organization.** (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency 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.

(2) Subsection (1) of this section does 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) 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) 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.

SECTION 27. 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 28. 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 mental health and behavioral 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 29. 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 30. Section 9, chapter 867, Oregon Laws 2009, as amended by section 47, chapter 828, Oregon Laws 2009, is amended to read:

Sec. 9. Managed care assessment. (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*] **"Coordinated care organization" means an organization that meets the criteria adopted by the Oregon Health Authority under section 4 of this 2011 Act**.

(2) No later than 45 days following the end of a calendar quarter, a [*Medicaid managed care*] **coordinated 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 during that calendar quarter **from the authority** 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*] **coordinated care organization**.

CONFORMING AMENDMENTS

SECTION 31. 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;

(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 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, listed by category of individual.

SECTION 32. 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 33. 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 34. 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 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 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 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 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 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 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 care and services to the authority as may be required by the authority for its records, reports and audits.

SECTION 35. 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 36. 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.

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

SECTION 37. 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.

SECTION 38. 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 39. 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 40. ORS 414.727 is amended to read:

414.727. (1) A [*prepaid managed care health services*] **coordinated care** organization[*, as defined in ORS 414.736,*] that contracts with the Oregon Health Authority under ORS 414.725 (1) to provide [*prepaid managed care health services*] **integrated and coordinated health care and services**, including hospital services, 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 cost-to-charge ratio used for each hospital in setting the [*capitation rates paid to the prepaid managed care health services*] **global budget for the coordinated care** organization for the contract period.

(2) The authority shall base the [*capitation rates*] **global budgets** described in subsection (1) of this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(3) This section may not be construed to prohibit a [*prepaid managed care health services*] **coordinated care** organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in subsection (1) of this section.

(4) Hospitals reimbursed under subsection (1) of this section are not entitled to any additional

reimbursement for services provided.

SECTION 41. ORS 414.728 is amended to read:

414.728. For services provided 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*] **coordinated care organization**, 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.

SECTION 42. 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 43. 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 44. 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 45. 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 46. 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 47. 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 48. 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 49. 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 50. 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 51. 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 52. ORS 735.615 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)(c), 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 or is eligible for Medicare;

(b) 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;

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

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

(e) 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

(f) 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) and subsection (3)(a) of this section, if a person 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) 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)(d) of this section.

SECTION 53. 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 **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 54. 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 55. 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 56. 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.

OPERATIVE AND EFFECTIVE DATES

SECTION 57. (1) Sections 3 to 15 of this 2011 Act and the amendments to statutes and session laws by sections 1, 2 and 16 to 54 of this 2011 Act become operative January 1, 2012.

(2) 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.

(3) The authority shall enter into contracts with coordinated care organizations and en-

roll medical assistance recipients in coordinated care organizations as soon as practicable after the operative date specified in this section.

SECTION 58. (1) ORS 414.610, 414.630, 414.640, 414.705, 414.736, 414.738, 414.739, 414.740, 414.741 and 414.742 are repealed January 1, 2012.

(2) Section 12 of this 2011 Act is repealed January 2, 2013.

(3) ORS 414.727 and 414.728 are repealed July 1, 2014.

SECTION 59. 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 on the operative dates specified in sections 57 and 58 of this 2011 Act including, but not limited to:

(1) Applying for necessary federal approval;

(2) Entering into contracts with coordinated care organizations; and

(3) Adopting rules.

SECTION 60. 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.

OHIT Oregon Legislative Bill Tracking 2011

Last Updated: 4/28/2011

Bill #	Relating To Clause	Summary	Last Three Actions	Committee(s) Assigned	Next Hearing	LC Filed By	OHIT Priority	Contact For Analysis	Analyses Available in U: Drive	Strategic Next Steps
SB 94 A	Relating to uniform standards for health care transactions; declaring an emergency.	Authorizes Department of Consumer and Business Services to adopt uniform standards for health care financial and administrative transactions of specified persons. Directs Oregon Health Authority to convene stakeholder work group to recommend standards for health care financial and administrative transactions and to report recommendations to department. Establishes procedure for department and authority to collaborate to ensure consistency in rules implementing uniform standards. Declares emergency, effective on passage.	04/27/11 - Public Hearing held. 04/12/11 - Referred to Health Care. 04/06/11 - First reading. Referred to the desks of the Co-Speakers.	Subcommittee On Health Care Reform, Health Care, Human Services and Rural Health Policy.	No hearings scheduled at this time.	OHA	**3**	Joseph Yedziniak (AMH) 2, Ali Hassoun (OEBB) 2, Lynn-Marie Crider (OHPR) 2, Mona McMullen (PEBB) 2	OHPR (Support)	If this bill passes, OHIT will want to work closely with OHA staff and the stakeholder WG to ensure coordination with HIE activities.
SB 96	Relating to the health care workforce; declaring an emergency.	Expands list of health professional regulatory boards subject to health care workforce data reporting to Office for Oregon Health Policy and Research. Declares emergency, effective on passage.	03/07/11 - Referred to Ways and Means by order of the President. 03/07/11 - Recommendation: Do pass. 03/02/11 - Public Hearing and Work Session held.	Subcommittee On Health Care Reform, Health Care, Human Services and Rural Health Policy.	No hearings scheduled at this time.	OHA	**3**	Lisa Angus (OHPR) 1, Robert Leopold (PHD) 2	OHPR (Support)	Watch for amendments that would weaken ability to use as foundation for ILPD
SB 107 A	Relating to public health tracking systems; declaring an emergency.	Clarifies that Oregon Health Authority may release information from immunization registry and tracking and recall system for purposes of outreach to clients who have missed public health interventions and for purposes of public health assessment and evaluation. Declares emergency, effective on passage.	05/02/11 - Public Hearing and Possible Work Session scheduled. 04/22/11 - Referred to Health Care. 04/19/11 - First reading. Referred to the desks of the Co-Speakers.	Health Care, Human Services and Rural Health Policy.	Date: Mon, May 02, 2011 Time: 3:00 PM Loc: HR D Com: Health Care (H)	OHA	**3**	Lorraine Duncan (PHD) 1	None	If passes, assess for any implications for consent policy.

SB 206	Relating to disclosure of protected health information.	Prohibits use and disclosure without patient authorization and for fundraising activities, protected health information held by health care providers, health insurers and health care clearinghouses.	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	Health Care, Human Services and Rural Health Policy	No hearings scheduled at this time.	Sen. Bates	**3**	Glenn Baly (OEBB) 2 , Sandy White-Gallardo (PEBB) 2	None	Clarify definition of fundraising activities to determine next steps. Questions sent to Amy Fauver 2/25.
SB 238 A	Relating to administrative requirements for persons contracting with the state to provide health services.	Limits patient data that must be reported to Oregon Health Authority by providers of mental health and addiction services. Requires authority to appoint rules advisory committee that includes specified members.	04/29/11 - Recommendation: Do pass with amendments. (Printed A-Eng.) 04/21/11 - Work Session held. 03/16/11 - Public Hearing held.	Health Care, Human Services and Rural Health Policy	No hearings scheduled at this time.	Senate Interim Committee on Health Care	**3**	Jon Collins (AMH) 1, Michael Morris (AMH) 1, Karen Wheeler (AMH) 1, Edie Woods (AMH) 1, Joseph Yedziniak (AMH) 1	None	Deals with required information for billing, not clinical information, but if enacted rulemaking should be tracked for possible long-term impacts when administrative data is incorporated into meaningful use.
SB 256	Relating to security of personal health care information; declaring an emergency.	Creates Task Force on Technology and Security of Personal Health Care Information. Sunsets task force on January 1, 2013. Declares emergency, effective on passage.	01/14/11 - Referred to Health Care, Human Services and Rural Health Policy, then Ways and Means. 01/10/11 - Introduction and first reading. Referred to Presidents desk	Health Care, Human Services and Rural Health Policy, then Ways and Means	No hearings scheduled at this time.	Senate Interim Committee on Human Services and Rural Health Policy	**1**	Natalie Barnes (ASD) 1	OHIT (Neutral)	Education around role of HITOC and Legal & Policy WG to avoid duplication of effort. Concerns sent to Amy Fauver 2/25.

SB 340	Relating to periodic legislative review of state government.	Directs Legislative Assembly to review state agencies and programs, taxes and fees administered by state agencies every six years. Abolishes state agencies that are not continued by legislative Act enacted during year of review. Establishes Sunset Advisory Commission. Directs commission to review and evaluate state agencies and programs, taxes and fees administered by state agencies and make recommendations on abolition or continuation of agencies and programs, taxes and fees administered by agencies. Provisions requiring review of state agencies and programs, taxes or fees administered by state agencies become operative January 1, 2013. Prohibits abolishment of state agency under Act until earlier of review of agency by Legislative Assembly or 2020.	04/14/11 - Public Hearing held. 01/18/11 - Referred to Rules. 01/10/11 - Introduction and first reading. Referred to Presidents desk.	Rules	No hearings scheduled at this time.	Sen. Winters, Boquist, Ferrioli, Girod, Kruse, Morse, Nelson, Starr, Whitsett; Rep. Berger	**2**	Natalie Barnes (ASD) 2, Shawn Jacobson (ASD) 2,	OHIT (Oppose)	This bill could be in play throughout the session since it was referred to Rules, so should be prepared to propose exclusion for public/private partnership of HIE.
SB 579 A	Relating to patient advocates; declaring an emergency	Allows hospital to appoint patient advocate to make health care decisions on behalf of patient incapable of making health care decisions. Declares emergency, effective on passage.effective on passage.	04/27/11 - Recommendation: Do pass with amendments. (Printed A-Eng.) 04/20/11 - Work Session held. 04/18/11 - Work Session held.	Health Care, Human Services and Rural Health Policy	No hearings scheduled at this time.	Sen. Johnson	**3**	Tina Kitchin (SPD) 1, Michael Morris (AMH) 2, Richard Varnum (AMH) 2	None	If passes, assess for implications for consent policy.
SB 787 A	Relating to telemedical health services.	Requires health benefit plan to provide coverage of telemedical health service provided in connection with treatment of diabetes that meets certain criteria if health service is otherwise covered by plan.	04/21/11 - Second reading. 04/20/11 - Recommendation: Do pass with amendments. (Printed A-Eng.) 04/14/11 - Work Session held.	Health Care, Human Services and Rural Health Policy.	No hearings scheduled at this time.	Sen. Atkinson, Monnes Anderson	**3**	Glenn Baly (OEBB) 2, Margaret Smith-Isa (PEBB) 2, Danna Hastings (PHD) 2 (OHA & OHPR have not assigned a bill manager)	None	Possible use case.

SB 860	Relating to health care; declaring an emergency.	[...Malpractice...Payment Standards...]Expands list of health professional regulatory boards subject to health care workforce data reporting to Office for Oregon Health Policy and Research. Authorizes Department of Consumer and Business Services to adopt uniform standards for health care financial and administrative transactions of specified persons. Authorizes Oregon Health Authority to convene stakeholder work group to recommend standards for health care financial and administrative transactions and to report recommendations to department.	04/21/11 - Public Hearing and Possible Work Session scheduled. 02/28/11 - Referred to Health Care, Human Services and Rural Health Policy, then Judiciary. 02/22/11 - Introduction and first reading. Referred to Presidents desk.	Health Care, Human Services and Rural Health Policy, then Judiciary	No hearings scheduled at this time.	Committee on Health Care, Human Services and Rural Health Policy (OHA)	**3**	Natalie Barnes (ASD) 2, Tina Kitchin (SPD) 2, Gretchen Morely (OHPR) 1, Michael Morris (AMH) 1, Margaret Smith-Isa (PEBB) 2, Joseph Yedziniak (AMH) 1	None	Determine difference between this and SB 94. Same post-session strategy.

HB 2061	Relating to electronic records of governmental agencies.	Permits governmental agency to conduct transaction electronically or create or retain electronic record of transaction without individual's agreement or consent if agency creates, sends, accepts, generates, communicates, stores, processes, uses or relies on electronic records regularly and in course of ordinary agency business. Permits agency to convert written records or records in other forms into electronic records.	05/02/11 - Public Hearing and Possible Work Session scheduled. 02/18/11 - Referred to General Government, Consumer and Small Business Protection. 02/15/11 - First reading. Referred to Presidents desk.	General Government and Consumer Protection	Date: Mon, May 02, 2011 Time: 1:00 PM Loc: HR B Com: General Government, Consumer and Small Business Protection (S)	DHS	**3**	Wendy Nelson-Baca (ASD) 1, Keely West (ASD) 2, Sandy Wood (DMAP) 2, Glenn Baly (OEBB) 2, Isabel Jolson (PEBB) 2	None	Determine if DOJ should assess for any implications for consent policy during rule making.
HB 2101	Relating to the implementation of a statewide electronic health information exchange.	Requires Oregon Health Authority to designate nonprofit entity to administer state policies and programs for electronic exchange of health information. Establishes board of directors to govern designated entity and specifies functions that entity may perform.	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means.01/10/11 - First reading. Referred to Speakers desk.	Health Care, then Ways and Means	No hearings scheduled at this time.	OHA	**3**	Linda Hammond (AMH) 2, Jon Collins (AMH) 2, Sandy Wood (DMAP) 2, Eve Ford (OPHP) 2, Lynn Hanson (OEBB) 2, Joseph Yedziniak (AMH) 2	DMAP (Support)	Placeholder bill. Determine is appropriate vehicle for fee legislation.
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HB 2102	Relating to health information; declaring an emergency.	Requires Oregon Health Authority to adopt rules consistent with state privacy statutes to govern use and disclosure of electronic health information under strategic health information technology plan. Exempts use and disclosure of health information pursuant to rules adopted by authority from requirements of other state laws. Declares emergency, effective on passage.	01/21/11 - Referred to Health Care. 01/10/11 - First reading. Referred to Speakers desk.	Health Care	No hearings scheduled at this time.	OHA	**3**	Jon Collins (AMH) 2, Eve Ford (OPHP) 2, Sandy Wood (DMAP) 2	DMAP (Neutral)	Placeholder bill. Determined by DOJ not to be needed.
HB 2224	Relating to individually identifiable health information.	Requires covered entities to report annually on system safeguards for protecting confidentiality of individually identifiable health information. Sunsets on January 2, 2014.	04/15/11 - Work Session held. 04/08/11 - Public Hearing held. 01/21/11 - Referred to Health Care.	Health Care	No hearings scheduled at this time.	Rep. Greenlick	**3**	Jane Alm (ASD) 2, Natalie Barnes (ASD) 2, Craig Urbani (OPHP) 2	None	Watch for implications to Qualification Program.

HB 2311	Relating to healthcare workforce data.	Specifies health care professionals and providers included in healthcare workforce database and expands list beginning January 2, 2013. Requires reporting of data for individual professionals and providers listed by provider number or other unique identifying number.	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	Health Care, then Ways and Means	No hearings scheduled at this time.	Rep. Dembrow	**3**	Jeanette Burket (SPD) 2, Elyssa Tran (OHPR) 2, Robert Leopold (PHD) 2	OHPR (Oppose)	Unlikely to move because of cost. However, could be used for ILPD.
HB 2377	Relating to Medicaid reimbursement of type B hospitals.	Modifies definition of 'type B hospital' for purposes of Medicaid reimbursement rates to require hospital to have five-year average operating margin of five percent or less. Requires Oregon Health Authority to prescribe methodology by rule for determining five-year average operating margin.	01/21/11 - Referred to Health Care. 01/11/11 - First reading. Referred to Speakers desk.	Health Care	No hearings scheduled at this time.	House Interim Committee on Health Care	**3**	Donald Ross (DMAP) 2, Sean Kolmer (OHPR) 2	OHPR (Support)	Nothing.
HB 2387	Relating to the Health Resources Commission; declaring an emergency.	Requires Health Resources Commission to develop and implement medical technology assessment program. Specifies procedures for medical technology assessment. Requires commission to appoint medical technology advisory committee to provide recommendations. Requires open meetings and public access to records. Declares emergency, effective on passage.	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	Health Care, then Ways and Means	No hearings scheduled at this time.	House Interim Committee on Health Care	**3**	Dave Pass (OHPR) 1	OHPR (Oppose)	Unlikely to move because of cost. Seems as though there should be a conversation between OHIT and OHPR about this concept.
HB 2857	Relating to regulatory requirements for health services providers; declaring an emergency.	Requires Oregon Health Authority to establish pilot program to implement uniform electronic processes for collecting data from health services providers that serve medical assistance recipients. Declares emergency, effective on passage.	01/21/11 - Referred to Health Care with subsequent referral to Ways and Means. 01/11/11 - First reading. Referred to Speakers desk.	Health Care, then Ways and Means	No hearings scheduled at this time.	Rep. Nathanson, Barker, Dembrow, Hoyle	**3**	Michael Morris (AMH) 1, Bill Bouska (AMH) 1, Joseph Yedziniak (AMH) 1, Mike McCormick (SPD) 2, Sandy Wood (DMAP) 2, Sean Kolmer (OHPR) 2,	DMAP (Neutral), OHPR (Support)	There should be some conversations about this one, perhaps at a SWAT meeting..

HB 2958	Relating to tracking the disbursement of funds from the American Recovery and Reinvestment Act of 2009; declaring an emergency.	Requires Department of Consumer and Business Services to compile and submit report to Legislative Assembly that identifies funds disbursed or distributed in this state under American Recovery and Reinvestment Act of 2009. Requires department to identify business entities that received funds under Act and categorize entities with particular attention to entities that meet definition of minority or women business enterprise, emerging small business or disadvantaged business enterprise. Sunsets January 1, 2014. Declares emergency, effective on passage.	05/04/11 - Public Hearing scheduled. 04/25/11 - Referred to Rules by order of the Co-Speakers. 04/25/11 - Without recommendation as to passage, be referred to Rules, and then to Ways and Means by prior reference.	General Government and Consumer Protection then Ways and Means.	Date: Wed, May 04, 2011 Time: 3:00 PM Loc: 50 Com: Rules (H)	Rep. Frederick, Bailey, Dembrow	**3**	Leah Craft (AMH) 3	None	
HB 2967 A	Relating to clinical laboratories.	Requires clinical laboratory to provide results of test to patient immediately upon patient's request.	03/14/11 - Referred to Health Care, Human Services and Rural Health Policy. 03/10/11 - First reading. Referred to Presidents desk. 03/09/11 - Third reading. Carried by Jenson. Passed.	Health Care	No hearings scheduled at this time.	Rep. Jenson	**3**	Michael Skeels (PHD) 2	None	Bring to lab stakeholder group if it moves forward.
HB 3110 A	Relating to substance abuse programs.	Removes sunset on Alcohol and Drug Policy Commission and adds members and advisory committee. Modifies and adds additional duties of commission. Requires commission to establish or approve minimum standards for drug prevention and treatment programs financed with state funds or with other funds administered by state.	4/07/11 - Referred to Ways and Means by order of Speaker. 04/07/11 - Recommendation: Do pass with amendments, be printed A-Engrossed, and be referred to Ways and Means. 04/04/11 - Work Session held.	Human Services, Ways and Means	No hearings scheduled at this time.	Rep. Tomei on behalf of the Alcohol Drug and Policy Commission	**3**	Mary Ellen Glynn (AMH) 1, Karen Wheeler (AMH) 1	None	Potential secondary use case for deidentified aggregate data. However, many substance abuse programs will fall under CRF 42 Part 2, so consent issues will be complicated.

HB 3195 A	Relating to electronic records; declaring an emergency.	Provides that if governmental agency conducts transaction by electronic means or in electronic form in ordinary course of business and under authority of law, agreement of person that conducts transaction with agency to conduct transaction by electronic means is presumed. [...etc.]	04/20/11 - Work Session held. 04/14/11 - Public Hearing and Work Session held. 03/31/11 - Public Hearing held.	General Government and Consumer Protection	No hearings scheduled at this time.	Rep. Esquivel	**3**	Jon Collins (AMH) 2, Wendy Nelson-Baca (ASD) 2, Edie Woods (AMH) 2	None	Determine if DOJ should assess for any implications for HIE consent policy if this bill is enacted.
HB 3381	Relating to residential care providers' compliance with orders of health professionals for individuals receiving residential care; declaring an emergency.	Requires Oregon Health Authority and Department of Human Services to adopt rules requiring residential facilities and homes to maintain systems to ensure that all medication and treatment orders by physicians and psychologists are carried out. Declares emergency, effective on passage.	02/28/11 - Referred to Human Services. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	Human Services	No hearings scheduled at this time.	Rep. Gelser, Doherty	**3**	Bill Bouska (AMH) 2, Michael Morris (AMH) 2, Julie Strauss (SPD) 2, Karen Wheeler (AMH) 2	None	Unlikely to move in current environment, but could help with issues raised by e-prescribe group.
HB 3435	Relating to health care assessment.	Requires Oregon Health Authority to convene workgroup to investigate options for health care assessment and to report findings and recommendations to 2012 Legislative Assembly. Sunsets on date of convening of 2013 regular session of Legislative Assembly.	02/28/11 - Referred to Health Care. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	Health Care	No hearings scheduled at this time.	Rep. Kotek	**3**	Margaret Smith-Isa (PEBB) 2, Russell Voth (OHPR) 2	None	Perhaps send HITOC Finance recommendation to Rep. Kotek. It would be good to know why she filed this.
HB 3442	Relating to medical assistance; declaring an emergency.	Requires Department of Human Services or Oregon Health Authority to implement biometric fingerprint identification system for medical assistance recipients. Requires hospitals to confirm biometric fingerprint identification of patient that presents for nonemergency care and offers medical assistance as payment for services. Applies to individuals who apply for or are recertified for medical assistance and to hospital services provided on or after date system is operational. Declares emergency, effective on passage.	02/28/11 - Referred to Human Services with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	Human Services, then Ways & Means	No hearings scheduled at this time.	Rep. Sheehan	**3**	Jeanette Burkette (SDS) 2, Marge Reinhart (CAF) 2, Donald Ross (DMAP) 2, Edie Woods (AMH) 2, Joseph Yedziniak (AMH) 2	None	Unlikely to move because of cost.

HB 3510	Relating to statewide coverage of health care; appropriating money.	Establishes Affordable Health Care for All Oregon Plan, operated by Oregon Health Authority according to policies established by Affordable Health Care for All Oregon Board. (Single Payer)	03/11/11 - Public Hearing held. 02/28/11 - Referred to Health Care with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	Health Care, then Ways & Means	No hearings scheduled at this time.	Rep. Dembrow, Bailey, Frederick, Greenlick, Nolan, Tomei, Sen. Dingfelder, Shields	**3**	Cindy Bowman (OPHP) 1, Jana Fussell (PHD) 1, Lynn Hanson (OEBB) 2, Gretchen Morely (OHPR) 1, Michael Morris (AMH) 1, Karen Wheeler (AMH) 1, Sandy Wood (DMAP) 2, Joseph Yedziniak (AMH) 2	None	Nothing at this time.
HB 3564	Relating to the creation of a Governor's Office of Information Technology; declaring an emergency.	Establishes Governor's Office of Information Technology and specifies powers, responsibilities and duties of office. Transfers responsibility for coordinating information technology portfolio management and other statewide information technology development and implementation from Oregon Department of Administrative Services to office. Becomes operative January 1, 2012. Declares emergency, effective on passage.	02/28/11 - Referred to General Government and Consumer Protection with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	General Government and Consumer Protection, Ways and Means.	No hearings scheduled at this time.	Rep. Harker, Huffman, Nathanson, J. Smith	**3**	None	None	Would impact organizational structure, but nothing to do unless legislation passes and restructuring begins.
HB 3565	Relating to information technology; declaring an emergency.	Directs Oregon Department of Administrative Services to conduct assessment of state's information technology environment.Directs Oregon Department of Administrative Services to create statewide information technology asset management framework. Directs Oregon Department of Administrative Services to establish Information Technologies Asset Management Office within department.	02/28/11 - Referred to General Government and Consumer Protection with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	General Government and Consumer Protection, Ways and Means.	No hearings scheduled at this time.	Rep. Harker, Huffman, Nathanson, J. Smith	**3**	None	None	Would impact organizational structure, but nothing to do unless legislation passes and restructuring begins.
HB 3566	Relating to information technology procurements; declaring an emergency.	Establishes Task Force on Information Technology Procurement and specifies membership.Requires task force to review and evaluate rules, policies, methods, standards and procedures that state contracting agencies use for information technology procurements under Public Contracting Code.	02/28/11 - Referred to General Government and Consumer Protection with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	General Government and Consumer Protection, Ways and Means.	No hearings scheduled at this time.	Rep. Harker, Huffman, Nathanson, J. Smith	**3**	None	None	Would impact organizational structure, but nothing to do unless legislation passes and restructuring begins.

HB 3568	Relating to information technology management for state agencies; declaring an emergency.	Requires Oregon Department of Administrative Services to establish project management process and certain standards for managing information technology projects for state government. Requires department to establish division of information technology project portfolio management and to develop or acquire suitable software for information technology project portfolio management. Requires department to report to Legislative Assembly. Becomes operative January 1, 2012. Declares emergency, effective on passage.	02/28/11 - Referred to General Government and Consumer Protection with subsequent referral to Ways and Means. 02/21/11 - First reading. Referred to the desks of the Co-Speakers.	General Government and Consumer Protection, Ways and Means.	No hearings scheduled at this time.	Rep. Harker, Huffman, Nathanson, J. Smith	**3**	None	None	Would impact organizational structure, but nothing to do unless legislation passes and restructuring begins.
HB 3650	Relating to health; declaring an emergency.	Health System Transformation Bill. Establishes Oregon Integrated and Coordinated Health Care Delivery System to replace managed care systems for recipients of medical assistance. Specifies criteria for coordinated care organizations. Allows sharing of confidential information within coordinated care organization.	04/27/11 - Public Hearing scheduled. 04/21/11 - Referred to Health Care Transformation. 04/21/11 - First reading. Referred to the desks of the Co-Speakers.	Health Care Transformation	Date: Wed, Apr 27, 2011 Time: 5:30 PM Loc: HR E Com: Health Care Transformation (J)	Joint Special Committee on Health Care Transformation	**3**	Gretchen Morely (OHPR) 2, Tina Kitchin (SPD) 2	None	