

**Health Systems Transformation Team**  
**LEGISLATIVE CONCEPT**  
**Preliminary Synopsis for Discussion Purposes**

**Primary Sources:**

Oregon Health Policy Board – Oregon’s Action Plan for Health (Dec. 2010)

And reports of OHPB advisory groups

Governor Kitzhaber’s Budget Report (January 2011)

Meetings of the Health System Transformation Team

**Assumptions:**

- This LC does not make any changes to eligible populations or covered benefits.
- This LC uses the existing statutory framework in ORS Chapter 414 (Medical Assistance) to describe changes to statute appropriate for transformed delivery system that applies integrated health and services.

**Key features of LC discussion draft:**

- Goals and policies for integrated health care and services
  - Adopt the goals of improving the health of Oregonians, increasing quality, reliability and available of care, and reducing costs of care.
  - Care and services are integrated and coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support.
  - Consumers get the care and services they need, coordinated locally with access to statewide resources when needed.
  - People are at the center of coordinated care and services delivered through accountable care organizations using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care.
- An accountable care organization is a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of the full continuum of care delivered to the specific population enrolled with the ACO.
- Essential elements of an ACO include (summarized);
  - (a) Work cooperatively with community partners to address public health issues;
  - (b) Health equity is prioritized and disparities are reduced;
  - (c) Actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered;
  - (d) Person-centered, providing integrated person-centered care and services designed to provide choice, independence and dignity;
  - (e) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery, including comprehensive transitional care;
  - (f) Local access to care, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;

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- (g) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate;
  - (h) Strong safeguards for consumers are established;
  - (i) Prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services;
  - (j) ACO providers work are educated about the integrated approach, emphasize preventive resources, healthy lifestyle choices and evidence-based practices, shared decision-making, and communication;
  - (k) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual to develop an individual care and service plan;
  - (l) Quality indicators are used; and
  - (m) Demonstrate excellence of operations.
- Related implementation changes and key definitions
    - Use of information and confidentiality
    - Cooperation & delegation authority between OHA and DHS
    - Grant authority for demonstration on integrated services for individuals who are dually eligible
    - Authority to seek federal approvals

NOTE: This LC does not attempt to identify all possible conforming amendments, pending review and comment on the LC.

**Legislative Concept  
Discussion Draft – Part 1**

**GOALS AND POLICIES**

**AMEND current law with updated goals and findings**

**GENERAL PROVISIONS**

**414.018 Goals; findings.** (1) It is the intention of the Legislative Assembly to achieve the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable for everyone.

**Deleted:** universal access to an adequate level of high quality health care at an affordable cost

(2) The Legislative Assembly finds:

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

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

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

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

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

(a) All health care and services are coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support;

(b) Including long term care supports and services in the transformed health system promotes and encourages greater utilization of home and community based services, with nursing facility care used primarily for transition services;

(c) Services for Oregonians who are fully eligible for both Medicare and Medicaid are included within the transformed health system;

(d) People are at the center of coordinated care and services delivered through accountable coordinated care contracts using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care;

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

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

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Discussion Draft – Part 1**

**GOALS AND POLICIES**

**AMEND current law with updated legislative intent (from OHPB Report p. 5)**  
**OREGON ACCOUNTABLE HEALTH CARE AND SERVICES SYSTEM**

**Deleted:** COST CONTAINMENT

**414.610 Legislative intent.** It is the intent of the Legislative Assembly to develop and implement new strategies to achieve an accountable and integrated system that improves health, increases the quality, reliability and availability of care, and reduces costs by creating a system in which:

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(1) Consumers to get the care and services they need, coordinated locally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;

(2) Consumers, providers, community leaders and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable;

(3) Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;

(4) Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health; and

(5) Electronic health information is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

**Deleted:** that promote and change the incentive structure in the delivery and financing of medical care, that encourage cost consciousness on the part of the users and providers while maintaining quality medical care and that strive to make state payments for such medical care sufficient to compensate providers adequately for the reasonable costs of such care in order to minimize inappropriate cost shifts onto other health care payers.

**AMEND current statute**

**414.620 System established.** (1) There is established the Oregon Accountable Health Care and Services System. The system shall consist of state policies and actions that make integrated care and services organizations accountable for care management and the provision of integrated health care and services for eligible persons, managed within a fixed budget by providing care better so that efficiency and quality improvements address medical inflation and, to the extent possible, caseload growth, and take these actions in a way that supports development of regional accountability for health, while maintaining the regulatory controls necessary to assure quality and affordable health services to all Oregonians.

**Deleted:** Cost Containment

(2) The Accountable Health Care and Services System should pay for quality while managing within a global budget. The system should hold accountable care organizations and their providers responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the health care system, restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes.

**Deleted:** encourage price competition among health care providers, that monitor services and costs of the health care system in Oregon, and that

(3) Alternative payment methodologies or methods will be used, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality rather than volume of services.

**Deleted:** 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.

**Legislative Concept  
Discussion Draft – Part 2**

**DELIVERY SYSTEM CHANGES**

**AMEND existing statute to describe procurement and requirements for accountable care organizations**

**414.725 Accountable care organization contracts; financial reporting; rules. (1)(a)**

Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute accountable care organization contracts for integrated health care and services funded by the Legislative Assembly. The contract must require that all health services defined in ORS 414.705(2) 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.

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(b) It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.

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(c) The authority shall solicit qualified providers or plans that meet the standards established in ORS 414.xxx [see new statute below] to be reimbursed for providing the integrated covered services as part of an accountable and coordinated health system. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private organization that meet the qualifications for an accountable care organization. After contracts are awarded pursuant to this section, the authority may negotiate with any successful proposal respondent for the expansion or contraction of service areas if there are potential gaps or duplications in service areas.

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**Deleted:** The authority may not discriminate against any contractors that offer services within their providers’ lawful scopes of practice

(d) The authority shall establish annual financial reporting requirements for accountable care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each accountable care organization and that includes information on the three highest executive salary and benefit packages of each accountable care organization.

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(e) The authority shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with an accountable care organization.

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(f)(A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of an accountable care organization receives total aggregate payments from the 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.

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(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).

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(2) The authority may contract for alternative innovative integrated health and services arrangements for the delivery of integrated services for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state as long as the alternative innovative arrangement meets the essential qualifications in ORS 414.xxx. For purposes of this chapter, a reference to a qualified entity providing integrated services under contract with the authority pursuant to this subsection shall be a reference to an accountable care organization, to the extent the Oregon Health Authority determines appropriate.

**Deleted:** institute a fee-for-service case management system or a fee-for-service payment system f

**Deleted:** or the same physical health, dental, mental health or chemical dependency services provided under the health

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

**Deleted:** 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.¶

(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 integrated 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.

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(5) Health care providers contracting with accountable care organizations to provide services under ORS 414.705 to 414.750 shall advise an ACO member of any service, treatment or test that is medically necessary or that could slow progression of loss of function 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.

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(6) An accountable care organization shall provide information on contacting available providers to an ACO member in writing within 30 days of assignment to the accountable care organization.

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(7) Each accountable care organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) An accountable care organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

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**NEW STATUTE to adopt "ESSENTIAL ELEMENTS" integration and accountability standards**

**ORS 414.xxx Essential elements for accountable care organization**

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Accountable care organizations are responsible for the full continuum of care for a defined population. Each accountable care organization or alternative integrated care system shall, at a minimum, have or obtain through contractual arrangement, the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority:

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(1) Accountable care organizations improve the quality of care, lower cost, and improve health and well-being of their members.

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**DELIVERY SYSTEM CHANGES**

- (a) The organization is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community.
  - (b) Health equity is prioritized and disparities are reduced. ACO organizational structures must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services, and ensure that ACO decision-making reflects the views of providers in the ACO network.
  - (c) The organization actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered.
- (2) Accountable care organizations are person-centered organizations that provide integrated person-centered care and services designed to provide choice, independence and dignity:
- (a) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery that address preventive, supportive and therapeutic needs of the individual in a holistic fashion, using person-centered primary care homes and individual care plans to the extent feasible, and that provides assistance in navigating the system if needed;
  - (b) Individuals receive comprehensive transitional care, including appropriate follow-up, when entering and leaving inpatient hospital or nursing facility to other care settings or return to their home;
  - (c) Access to services and supports are geographically located as close to home as possible, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;
  - (d) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate; and
  - (e) Strong safeguards for consumers are established, including safeguards against underutilization of services and protections against inappropriate denials of services or treatments in connection with utilization of alternative payment methods or transition to a global payment system.
- (3) Accountable care organizations prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the use of services provided in emergency rooms and hospital readmissions.
- (4) The accountable care organization’s providers work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of individuals:
- (a) Providers are educated about the integrated approach, and how to access and communicate within the integrated system about an individual’s plan and health history.

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- (b) Providers emphasize preventive resources, healthy lifestyle choices and evidence-based practices, shared decision-making, and communication.
- (c) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual’s needs as a whole person, and work with the individual to develop an individual care and service plan
- (d) Providers maximize use of electronic health records to assure continuity of care across the service delivery system.
- (5) Quality indicators are evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.
- (6) Accountable care organizations demonstrate excellence of operations, including best practices in financial management capabilities, including but not limited to the management of claims processing and payment functions for ACO providers, and contract management capabilities, including but not limited to network provider creation and management functions.

**NEW – Language for the service delivery expectations for individuals who are dually eligible –**

**414.xxx Conditions for coverage for certain individuals who are dually eligible for Medicare and Medicaid** (1) Accountable care organizations that meet the standards established in ORS 414.xxx [above] are responsible for providing Medicare and Medicaid services to individuals who are dually eligible, including obtaining any necessary authorization from Medicare.

(2) Care and services for individuals who are dually eligible must emphasize preventive services, and services supporting independence and continued residence at home or in their community. Services for individuals who are dually eligible must be person-centered, and provide choice, independence and dignity reflected in individual plans and assistance with accessing care and services.

(3) The Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services to seek approval of contracting procedures and blended reimbursement methods for accountable care organizations responsible for enrolled individuals who are dually eligible.

**AMEND Current statute for patient-centered primary care home services –**

**414.760 Person centered primary care home services.** (1) The Oregon Health Authority shall establish standards for implementation and utilization of person centered primary care homes and encourage their use in contracts with accountable care organizations. If practicable, efforts to align financial incentives to support person

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<b>Deleted:</b> As funds are available, the Oregon Health Authority may provide reimbursement in the state’s medical assistance program for services provided by patient centered primary care homes.
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**DELIVERY SYSTEM CHANGES**

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) Each accountable care organization shall implement, to the maximum extent feasible, person 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 with the primary care home in a timely manner and participate in care coordination including use of electronic health information technology. The authority may reimburse person 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.

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

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**RELATED IMPLEMENTATION RECOMMENDATIONS**

**NEW STATUTE for coordination and delegation of authority between DHS and OHA for implementation**

- (1) The Department of Human Services and the Oregon Health Authority shall cooperate with each other by coordinating actions and responsibilities necessary to implement an accountable and integrated health and service delivery system in accordance with this 2011 Act, in a manner consistent with the responsibilities of the authority for the medical assistance program pursuant to ORS 413.032.
- (2) The department and the authority may delegate to each other any duties, functions or powers that the department or the authority deem necessary for the efficient and effective operation of their respective functions for purposes of this 2011 Act.

**NEW STATUTE for use of information sharing and confidentiality**

**414.xxx Disclosure and use of medical assistance records by ACOs limited; contents as privileged communication; exceptions.** (1) A hallmark of integrated accountable care organizations' effective management and service delivery is the appropriate use of ACO member information which includes use of electronic health information and administrative data that is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

(2) ACO members must have access to their personal health information, in the manner provided in 45 CFR 164.524, so they can share it with others involved in their care and make better health care and lifestyle choices.

(3) An accountable care organization and its provider network shall use and disclose ACO member information for purposes of service and care delivery, coordination, service planning, transitional services, reimbursement, and the requirements of this chapter, in order to improve the safety and quality of care, lower the cost, and improve health and well-being of their members. Integrated whole-person care necessarily requires access to and use of information about all aspects of the person's health and mental health condition, and sensitive diagnosis information including HIV and other health and mental health diagnoses, within the accountable care organization. Such uses and disclosures by the accountable care organization and its providers for purposes of providing integrated health care and services is required by law in accordance with this section. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.526 and applicable federal privacy requirements, and redisclosures outside of the accountable care organization and its providers for purposes unrelated to this section or the requirements of this chapter remain subject to any applicable state privacy requirements.

(4) For the protection of ACO members, except as otherwise provided in this section, an accountable care organization and its providers shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the administration of the ACO and the public assistance laws of Oregon, or as necessary to assist the ACO members in accessing and receiving other

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**RELATED IMPLEMENTATION RECOMMENDATIONS**

governmental or private nonprofit services, and these records, files, papers and communications are considered confidential subject to the rules and regulations of the Oregon Health Authority. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance or child support enforcement laws, their contents are considered privileged communications.

(5) Nothing in this section prohibits disclosure of information between the ACO and its provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the public assistance laws of Oregon.

**AMEND – This is the state mini-HIPAA privacy law; need to amend to address privacy issues**

**192.519 Definitions for ORS 192.518 to 192.529.** As used in ORS 192.518 to 192.529:  
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(2) “Covered entity” means:

- (a) A state health plan;
- (b) A health insurer;
- (c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or
- (d) A health care clearinghouse.
- (e) An accountable care organization contracted with the Oregon Health Authority

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**AMEND current statute related to grant authority for demonstration on integrated services for individuals who are dually eligible**

**414.033 Expenditures for medical assistance authorized.** 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 providing medical assistance to individuals who are dually eligible, or to evaluates service delivery systems.

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**NEW STATUTE Necessary federal approvals may be requested**

(1) To promote the adoption of alternative payment methodologies and contracting with ACOs, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services for

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**RELATED IMPLEMENTATION RECOMMENDATIONS**

any approval necessary to obtain federal financial participation in the costs of activities described in this 2011 Act, including but not limited to:

(a) Seeking federal approvals necessary to permit Medicare to participate in Oregon’s alternative payment and integrated 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.

(b) Seeking federal approvals necessary to support the transition to and implementation of global and alternative payment systems, and formation and utilization of ACOs in the medical assistance program.

(2) The authority shall adopt rules implementing the provisions of this 2011 Act requiring federal approval 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.

(3) Sections of this 2011 Act requiring federal approvals become operative on the later of \_\_\_\_\_, or the date on which the Oregon Health Authority receives any federal approval required to secure federal financial participation under subsection (1) of this section.

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Discussion Draft – Part 4**

**KEY DEFINITIONS**

**AMEND current statute defining “medical assistance”**

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

\*\*\* [NO CHANGES IN POPULATIONS COVERED OR DEFINITIONS OF “INCOME” OR “INVESTMENTS AND SAVINGS”]

(5) “Medical assistance” is synonymous with “integrated health care and services” or “integrated services”, which means so much of the following preventive, medical, remedial and supportive care and services as may be funded by the Legislative Assembly and prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

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- (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, and other long term care services and supports;
- (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;

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**KEY DEFINITIONS**

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

(s) Hospice services;

(t) Home and community based services;

(u) Mental health services; and

(v) Chemical dependency services.

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(6) “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) [OMIT DEFINITION OF MEDICALLY NEEDY – NOT CHANGED; COULD BE REPEALED, SINCE NO MEDICALLY NEEDY PROGRAM AT THIS TIME]

(8) [OMIT DEFINITION OF RESOURCES – NOT CHANGED]

(9) “Individual who is dually eligible” means an individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII, or enrolled for benefits under Part B of Title XVIII, and is eligible for medical assistance under Title XIX of the Social Security Act in accordance with this chapter.

(10) “Person-centered primary care home” means a primary care team or clinic which is organized in accordance with standards as defined by the Oregon Health Authority and which incorporates the following core attributes:

(a) Access to care;

(b) Accountability;

(c) Comprehensive whole person care;

(d) Continuity;

(e) Coordination and integration; and

(f) Person and family centered care.

(10) “Accountable care organization” or “ACO” means a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the ACO; which operates consistent with the principles of a person-centered primary care home and satisfies the other requirements of this chapter; which has a formal legal structure to receive global payments and distribute payments and savings; and which complies with any federal requirements applicable to ACOs, however named. An ACO may include an alternative innovative integrated health and services arrangement approved by the authority in accordance with ORS 414.725.

(11) “ACO member” means an individual who receives integrated medical, remedial and supportive care and services through an accountable care organization.

(12) “Alternative payment methodologies or methods” means methods of payment that are not fee-for-service based and that are used by ACOs to compensate their providers for the provision of integrated health care and services, including but not limited to shared savings arrangements, bundled payments, episode-based payments, and

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**KEY DEFINITIONS**

global payments, as defined by rules adopted by the Oregon Health Authority. No payment based on the fee-for-service methodology shall be considered an alternative payment.

(13) “Quality measures” means objective benchmarks established in accordance with nationally accepted performance metrics and as otherwise permitted under this chapter for assessing provider and ACO performance.

**AMEND current statute to define “integrated health care and services”**

**414.705 Definitions for ORS 414.705 to 414.750.** (1) As used in ORS 414.705 to 414.750, “integrated health care and services” or “integrated services” means at least so much of medical assistance as defined in ORS 414.025, including health services, as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032 and that are approved and funded by the Legislative Assembly. (2) “Health services” means so much of the following care and services funded by the Legislative Assembly in accordance with the prioritized list of health services under ORS 414.720:

- (a) Services required by federal law to be included in the state’s medical assistance program in order for the program to qualify for federal funds;
- (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as defined by state law, and ambulance services;
- (c) Prescription drugs;
- (d) Laboratory and X-ray services;
- (e) Medical 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.

**Deleted:** (2) Health services approved and funded under subsection (1) of this section are subject to the prioritized list of health services required in ORS 414.720. ¶