

**A-Engrossed**  
**House Bill 2986**

Ordered by the House April 12  
Including House Amendments dated April 12

Sponsored by Representative ALONSO LEON, Senator MONNES ANDERSON; Representatives KENY-GUYER, MITCHELL, NOSSE

**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.

Requires Oregon Health Authority and coordinated care organizations to partner with regional health equity coalitions in addressing health disparities for communities of color, **Indian tribes, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, persons with disabilities and lesbian, gay, bisexual, transgender and questioning communities, with communities of color as leading priority.** Describes regional health equity coalitions.

Requires authority and coordinated care organizations to [*award grants*] **provide funding** to support work of regional health equity coalitions **that meet specified criteria.**

**Requires authority to appoint regional health equity coalition fidelity committee to oversee regional health equity coalitions statewide and establish funding criteria for coalitions.**

Declares emergency, effective July 1, 2019.

**A BILL FOR AN ACT**

1  
2 Relating to reducing health disparities for minority communities; creating new provisions; amending  
3 ORS 414.625; and declaring an emergency.

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

5 **SECTION 1. (1) As used in this section:**

6 (a) **“Base funding” means fiscal resources that provide necessary infrastructure support,**  
7 **capable of quickly adjusting to reflect changing demands, to allow a regional health equity**  
8 **coalition to focus its priorities on work that communities of color indicate are the most im-**  
9 **portant.**

10 (b) **“Community-led” means an approach based on a set of core principles that, at a**  
11 **minimum, engages the people living in a geographic community to establish goals and prior-**  
12 **ities, using local residents as leaders, building on strengths rather than focusing on problems**  
13 **and involving cross-sector collaboration that is intentional and adaptable and works to**  
14 **achieve systemic change.**

15 (c) **“Coordinated care organization” has the meaning given that term in ORS 414.025.**

16 (d) **“Cross-sector” means involving individuals, public and private institutions and com-**  
17 **munities working together.**

18 (e) **“Health equity” has the meaning prescribed by the Oregon Health Policy Board by**  
19 **rule based on the recommendation of the board’s committee on health equity.**

20 (f) **“Infrastructure support” includes:**

21 **(A) Building coalitions;**

22 **(B) Developing and solidifying governance structures;**

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

1 (C) Conducting capacity building activities to further develop skills related to health eq-  
2 uity; and

3 (D) Assessing community needs.

4 (g) “Meaningful community engagement” means working collaboratively with and  
5 through groups of individuals who are affiliated by geographic proximity, special interest or  
6 similar situations to address issues affecting the well-being of the groups.

7 (h) “Office of Equity and Inclusion” means the office within the Oregon Health Authority  
8 that works with diverse communities to eliminate health gaps and promote optimal health  
9 in Oregon.

10 (2) The authority and a coordinated care organization must, to the greatest extent  
11 practicable, partner with a regional health equity coalition that is an autonomous,  
12 community-led, cross-sector group that is completely independent of coordinated care or-  
13 ganizations and government agencies and that:

14 (a) Identifies sustainable, long term policies and systemic and environmental solutions  
15 to improve health equity for underserved communities of color, Oregon’s nine federally re-  
16 cognized Indian tribes, immigrants, refugees, migrant and seasonal farmworkers, low-income  
17 populations, persons with disabilities and lesbian, gay, bisexual, transgender and questioning  
18 communities in rural and urban areas, with communities of color as the leading priority; and

19 (b) Focuses on:

20 (A) Meaningful community engagement;

21 (B) Coalition building, developing a governance structure for the coalition and creating  
22 operating systems for the daily and long term functioning of the coalition led by individuals  
23 with demonstrated leadership and expertise in promoting and improving health equity;

24 (C) Building capacity and leadership among coalition members, staff and decision-making  
25 bodies to address health equity and the social determinants of health; and

26 (D) Developing and advocating for policy, system and environmental changes to improve  
27 health equity in this state.

28 (3)(a) To ensure that regional health equity coalitions are able to fully engage in the work  
29 described in this section:

30 (A) The authority shall provide funding to regional health equity coalitions; and

31 (B) Coordinated care organizations shall provide funding to regional health equity coali-  
32 tions through negotiated contracts.

33 (b) To receive funding under this subsection, a regional health equity coalition must:

34 (A) Have a minimum of two years of experience providing services to or programming  
35 for at least one community of color;

36 (B) Have a minimum of two years of experience addressing health disparities or pro-  
37 moting health equity for one or more communities of color;

38 (C) Be a federally recognized Indian tribe in Oregon or one of the following community-  
39 based nonprofit organizations:

40 (i) A culturally specific organization;

41 (ii) A social service provider;

42 (iii) A health care organization;

43 (iv) A public health research organization;

44 (v) A behavioral health organization;

45 (vi) A private foundation; or

1 (vii) A faith-based organization;

2 (D) Be organized to focus on addressing health disparities of underserved communities  
3 of color, Oregon's nine federally recognized Indian tribes, immigrants, refugees, migrant and  
4 seasonal farmworkers, low-income populations, persons with disabilities and lesbian, gay,  
5 bisexual, transgender and questioning communities in rural and urban areas;

6 (E) Have 51 percent or more of the leadership positions or members of the decision-  
7 making body of the coalition be persons of color;

8 (F) Be led in the development of the coalition's objectives and strategic priorities by  
9 members of the communities most affected by health disparities; and

10 (G) Involve in its activities a range of community partners, including a range of cul-  
11 turally specific community-based organizations, Oregon's nine federally recognized Indian  
12 tribes and public agencies.

13 (4) The authority shall establish formal partnerships with regional health equity coali-  
14 tions and seek out consultation with and technical assistance from regional health equity  
15 coalitions to identify sustainable, long term policy, system and environmental solutions to  
16 increase health equity for communities of color and other marginalized groups.

17 (5)(a) The authority shall appoint and support the work of a regional health equity co-  
18 alition fidelity committee to oversee the regional health equity coalitions in this state that  
19 have partnered with coordinated care organizations. The committee may have up to 13  
20 members and must include at least one representative from each of the regional health eq-  
21 uity coalitions receiving funding from the authority through the Office of Equity and Inclu-  
22 sion and at least one individual from the office.

23 (b) The committee shall:

24 (A) Conduct annual evaluations of coordinated care organizations to assess their com-  
25 pliance with the requirements of this section related to establishing partnerships, providing  
26 support and developing and advocating for health equity-related policies, system changes and  
27 environmental changes identified by the regional health equity coalition as described in sub-  
28 section (2) of this section;

29 (B) Provide directives to each coordinated care organization based on the findings from  
30 the annual evaluation to ensure that the coordinated care organization has implemented  
31 health equity-related policies, system changes and environmental changes; and

32 (C) Establish funding criteria for regional health equity coalitions that are partnered with  
33 coordinated care organizations.

34 (6)(a) Each coordinated care organization that has a regional health equity coalition in  
35 the coordinated care organization's region shall form a meaningful partnership with the re-  
36 gional health equity coalition and develop a mutually agreed upon scope of work with suffi-  
37 cient resources negotiated by contract. Regional health equity coalitions may decline  
38 partnerships for any reason.

39 (b) Partnerships between regional health equity coalitions and coordinated care organ-  
40 izations should be further developed through future rulemaking by the authority, based on  
41 coordinated care organization contracts and feedback from all stakeholder groups, including  
42 what potential partnerships between coordinated care organizations and regional health eq-  
43 uity coalitions could entail.

44 (7) Each coordinated care organization that does not have a regional health equity co-  
45 alition in the coordinated care organization's region shall seek out partnerships with local

1 **culturally specific community-based organizations and Oregon's nine federally recognized**  
2 **Indian tribes through continuous base funding opportunities to create regional health equity**  
3 **coalitions in the coordinated care organization's region in consultation with the regional**  
4 **health equity coalition fidelity committee.**

5 **SECTION 2.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended  
6 to read:

7 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
8 quirements for a coordinated care organization and shall integrate the criteria and requirements  
9 into each contract with a coordinated care organization. Coordinated care organizations may be  
10 local, community-based organizations or statewide organizations with community-based participation  
11 in governance or any combination of the two. Coordinated care organizations may contract with  
12 counties or with other public or private entities to provide services to members. The authority may  
13 not contract with only one statewide organization. A coordinated care organization may be a single  
14 corporate structure or a network of providers organized through contractual relationships. The cri-  
15 teria and requirements adopted by the authority under this section must include, but are not limited  
16 to, a requirement that the coordinated care organization:

17 (a) Have demonstrated experience and a capacity for managing financial risk and establishing  
18 financial reserves.

19 (b) Meet the following minimum financial requirements:

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

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

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

30 (c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as de-  
31 fined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care  
32 organization's total expenditures for physical and mental health care provided to members, except  
33 for expenditures on prescription drugs, vision care and dental care.

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

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

38 (f) Engage community members and health care providers in improving the health of the com-  
39 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that  
40 exist among the coordinated care organization's members and in the coordinated care organization's  
41 community.

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

45 (a) Each member of the coordinated care organization receives integrated person centered care

1 and services designed to provide choice, independence and dignity.

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

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

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

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

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

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

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

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

24 (j) Each coordinated care organization prioritizes working with members who have high health  
25 care needs, multiple chronic conditions, mental illness or chemical dependency and involves those  
26 members in accessing and managing appropriate preventive, health, remedial and supportive care  
27 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-  
28 gency room visits and hospital admissions.

29 (k) Members have a choice of providers within the coordinated care organization's network and  
30 that providers participating in a coordinated care organization:

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

33 (B) Are educated about the integrated approach and how to access and communicate within the  
34 integrated system about a patient's treatment plan and health history.

35 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-  
36 making and communication.

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

38 (E) Include providers of specialty care.

39 (F) Are selected by coordinated care organizations using universal application and credentialing  
40 procedures and objective quality information and are removed if the providers fail to meet objective  
41 quality standards.

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

44 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
45 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464

1 and 442.466.

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

4 (n) Each coordinated care organization participates in the learning collaborative described in  
5 ORS 413.259 (3).

6 (o) Each coordinated care organization has a governing body that complies with section 2,  
7 chapter 49, Oregon Laws 2018, and that includes:

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

10 (B) A representative of a dental care organization selected by the coordinated care organization;

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

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

13 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS  
14 678.375, whose area of practice is primary care; and

15 (ii) A mental health or chemical dependency treatment provider;

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

18 (F) At least one member of the community advisory council.

19 (p) Each coordinated care organization's governing body establishes standards for publicizing  
20 the activities of the coordinated care organization and the organization's community advisory  
21 councils, as necessary, to keep the community informed.

22 **(q) Coordinated care organizations partner with regional health equity coalitions as re-**  
23 **quired by section 1 of this 2019 Act.**

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

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

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

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

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

32 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
33 relationship with any dental care organization that serves members of the coordinated care organ-  
34 ization in the area where they reside.

35 **SECTION 3.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and sec-  
36 tion 4, chapter 49, Oregon Laws 2018, is amended to read:

37 414.625. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and re-  
38 quirements for a coordinated care organization and shall integrate the criteria and requirements  
39 into each contract with a coordinated care organization. Coordinated care organizations may be  
40 local, community-based organizations or statewide organizations with community-based participation  
41 in governance or any combination of the two. Coordinated care organizations may contract with  
42 counties or with other public or private entities to provide services to members. The authority may  
43 not contract with only one statewide organization. A coordinated care organization may be a single  
44 corporate structure or a network of providers organized through contractual relationships. The cri-  
45 teria and requirements adopted by the authority under this section must include, but are not limited

1 to, a requirement that the coordinated care organization:

2 (a) Have demonstrated experience and a capacity for managing financial risk and establishing  
3 financial reserves.

4 (b) Meet the following minimum financial requirements:

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

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

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

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

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

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

23 (f) Engage community members and health care providers in improving the health of the com-  
24 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that  
25 exist among the coordinated care organization's members and in the coordinated care organization's  
26 community.

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

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

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

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35 using patient centered primary care homes, behavioral health homes or other models that support  
36 patient centered primary care and behavioral health care and individualized care plans to the extent  
37 feasible.

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

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

44 (f) Services and supports are geographically located as close to where members reside as possi-  
45 ble and are, if available, offered in nontraditional settings that are accessible to families, diverse

1 communities and underserved populations.

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

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

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

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12 and services, including the services described in ORS 414.766, to reduce the use of avoidable emer-  
13 gency room visits and hospital admissions.

14 (k) Members have a choice of providers within the coordinated care organization's network and  
15 that providers participating in a coordinated care organization:

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

18 (B) Are educated about the integrated approach and how to access and communicate within the  
19 integrated system about a patient's treatment plan and health history.

20 (C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-  
21 making and communication.

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

23 (E) Include providers of specialty care.

24 (F) Are selected by coordinated care organizations using universal application and credentialing  
25 procedures and objective quality information and are removed if the providers fail to meet objective  
26 quality standards.

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

29 (L) Each coordinated care organization reports on outcome and quality measures adopted under  
30 ORS 414.638 and participates in the health care data reporting system established in ORS 442.464  
31 and 442.466.

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

34 (n) Each coordinated care organization participates in the learning collaborative described in  
35 ORS 413.259 (3).

36 (o) Each coordinated care organization has a governing body that complies with section 2,  
37 chapter 49, Oregon Laws 2018, and that includes:

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

40 (B) A representative of a dental care organization selected by the coordinated care organization;

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

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

43 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS  
44 678.375, whose area of practice is primary care; and

45 (ii) A mental health or chemical dependency treatment provider;



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

3 (F) At least one member of the community advisory council.

4 (p) Each coordinated care organization's governing body establishes standards for publicizing  
5 the activities of the coordinated care organization and the organization's community advisory  
6 councils, as necessary, to keep the community informed.

7 **(q) Coordinated care organizations partner with regional health equity coalitions as re-**  
8 **quired by section 1 of this 2019 Act.**

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

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

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

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

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

17 (5) On or before July 1, 2014, each coordinated care organization must have a formal contractual  
18 relationship with any dental care organization that serves members of the coordinated care organ-  
19 ization in the area where they reside.

20 **SECTION 4. In addition to and not in lieu of any other appropriation, there is appropri-**  
21 **ated to the Oregon Health Authority, to be used by the office within the authority that is**  
22 **charged with addressing equity and inclusion, for the biennium beginning July 1, 2019, out**  
23 **of the General Fund, the amount of \$380,000, which shall be expended for increasing funding**  
24 **to the six regional health equity coalitions operating on the effective date of this 2019 Act.**  
25 **The appropriation under this section may not be used for staffing and program costs for the**  
26 **Office of Equity and Inclusion, as defined in section 1 of this 2019 Act, that are associated**  
27 **with the regional health equity coalition fidelity committee appointed under section 1 of this**  
28 **2019 Act.**

29 **SECTION 5. This 2019 Act being necessary for the immediate preservation of the public**  
30 **peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect**  
31 **July 1, 2019.**

32