SENATE AMENDMENTS TO SENATE BILL 735

By COMMITTEE ON HEALTH CARE

April 16

On page 1 of the printed bill, line 2, after "ORS" delete the rest of the line and line 3 and insert "243.135, 243.866, 413.017, 413.032, 414.025, 414.065, 414.625, 414.638, 414.652, 417.721 and 743B.200 and sections 1 and 3, chapter 389, Oregon Laws 2015, and section 2, chapter 575, Oregon Laws 2015.".

Delete lines 5 through 28 and delete pages 2 through 4 and insert:

"**SECTION 1.** ORS 413.017 is amended to read:

"413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) to (4) of this section.

"(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

"(A) The Public Employees' Benefit Board.

"(B) The Oregon Educators Benefit Board.

"(C) Trustees of the Public Employees Retirement System.

"(D) A city government.

"(E) A county government.

"(F) A special district.

"(G) Any private nonprofit organization that receives the majority of its funding from the state and requests to participate on the committee.

"(b) The Public Health Benefit Purchasers Committee shall:

"(A) Identify and make specific recommendations to achieve uniformity across all public health benefit plan designs based on the best available clinical evidence, recognized best practices for health promotion and disease management, demonstrated cost-effectiveness and shared demographics among the enrollees within the pools covered by the benefit plans.

"(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

"(C) Continuously review and report to the Oregon Health Policy Board on the committee's progress in aligning benefits while minimizing the cost shift to individual purchasers of insurance without shifting costs to the private sector or the health insurance exchange.

"(c) The Oregon Health Policy Board shall work with the Public Health Benefit Purchasers Committee to identify uniform provisions for state and local public contracts for health benefit plans that achieve maximum quality and cost outcomes. The board shall collaborate with the committee to develop steps to implement joint contract provisions. The committee shall identify a schedule for the implementation of contract changes. The process for implementation of joint contract provisions must include a review process to protect against unintended cost shifts to enrollees or agencies.

"(3)(a) The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.

"(b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population.

"(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

"(4)(a) The Health [*Plan*] Quality Metrics Committee shall include the following members appointed by the Governor:

"(A) An individual representing the Oregon Health Authority;

"(B) An individual representing the Oregon Educators Benefit Board;

"(C) An individual representing the Public Employees' Benefit Board;

"(D) An individual representing the Department of Consumer and Business Services;

"(E) Two health care providers;

"(F) One individual representing hospitals;

"(G) One individual representing insurers, large employers or multiple employer welfare arrangements;

"(H) Two individuals representing health care consumers;

"(I) Two individuals representing coordinated care organizations;

"(J) One individual with expertise in health care research;

"(K) One individual with expertise in health care quality measures; [*and*]

"(L) One individual with expertise in mental health and addiction services**;**

"(M) One individual with expertise in oral health and dental care;

"(N) One individual who represents rural hospitals; and

"(O) One individual who represents insurers that offer health benefit plans to small employers.

"(b) The committee shall work collaboratively with the Oregon Educators Benefit Board, the Public Employees' Benefit Board, the Oregon Health Authority and the Department of Consumer and Business Services to adopt [*health outcome and quality*] measures **of health outcomes and health care quality** that are focused on specific goals and provide value to the state, employers, insurers, health care providers and consumers. The committee shall be the single body to align [*health outcome and quality*] measures **of health outcomes and health care quality** used in this state with the requirements of health care data reporting to ensure that the measures and requirements are coordinated, evidence-based and focused on a long term statewide vision.

"(c)**(A)** The committee shall use a public process that includes an opportunity for public comment to identify [*health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board.*] **measures of health outcomes and health care quality applicable to:**

"(i) Health care provided by coordinated care organizations;

"(ii) Inpatient and outpatient services provided by hospitals; and

"(iii) Health care paid for by health benefit plans sold in this state.

"(B) The committee shall identify the category of services to which each measure applies and may recommend a core set of measures to be adopted for all categories.

"(C) The Oregon Health Authority, the Department of Consumer and Business Services, the Oregon Educators Benefit Board and the Public Employees' Benefit Board are not required to adopt all of the [*health outcome and quality*] measures **of health outcomes and health care quality** identified by the committee **for their own use** but may not adopt any [*health outcome and quality*] measures **of health outcomes and health care quality** that are different from the measures identified by the committee.

"**(D)** The measures must take into account the recommendations of the metrics and scoring subcommittee created in ORS 414.638 and the differences in the populations served by coordinated care organizations and by commercial insurers.

"(d) In identifying [*health outcome and quality*] measures **of health outcomes and health care quality**, the committee shall prioritize measures that:

"(A) Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed by other state or national organizations and have a relevant state or national benchmark;

"(B) [*Given the context in which each measure is applied, are not prone to random variations based on the size of the denominator*] **Are likely to generate valid and reliable results**;

"(C) Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden on the state, health benefit plans and health care providers;

"(D) Can be meaningfully adopted for a minimum of three years;

"(E) Use a common format in the collection of the data and facilitate the public reporting of the data; [*and*]

"(F) Can be reported in a timely manner and without significant delay so that the most current and actionable data is available**; and**

"(G) Align with statewide strategic goals for the improvement of health and health care.

"(e) The committee shall evaluate on a regular and ongoing basis the [*health outcome and quality*] measures **of health outcomes and health care quality** adopted under this section.

"(f) The committee may convene subcommittees to focus on gaining expertise in particular areas such as data collection, health care research and mental health and substance use disorders in order to aid the committee in the development of [*health outcome and quality*] measures **of health outcomes and health care quality**. A subcommittee may include stakeholders and staff from the Oregon Health Authority, the Department of Human Services, the Department of Consumer and Business Services, the Early Learning Council or any other agency staff with the appropriate expertise in the issues addressed by the subcommittee.

"(g) This subsection does not prevent the Oregon Health Authority, the Department of Consumer and Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon Educators Benefit Board from establishing programs that provide financial incentives to providers for meeting specific [*health outcome and quality*] measures **of health outcomes and health care quality** adopted by the committee.

"(5) Members of the committees described in subsections (2) to (4) of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses in-

curred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

"**SECTION 2.** ORS 743B.200 is amended to read:

"743B.200. Each [*insurer*] **carrier** offering [*managed health insurance*] **a health benefit plan** in this state shall:

"(1) Have a quality assessment program that enables the insurer to evaluate, maintain and improve the quality of health services provided to enrollees **and the health outcomes of enrollees using, at a minimum, the measures adopted by the Health Quality Metrics Committee under ORS 413.017 (4)(c)**. The program shall include data gathering that allows the plan to measure progress on specific quality improvement goals chosen by the insurer.

"(2) File an annual summary with the Department of Consumer and Business Services that describes quality assessment activities, including any activities related to credentialing of providers, and reports any progress on the insurer's quality improvement goals.

"(3) File annually with the department the following information:

"(a) Results of all publicly available federal Centers for Medicare and Medicaid Services reports and accreditation surveys by national accreditation organizations.

"(b) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer.

"**SECTION 3.** ORS 243.135 is amended to read:

"243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

"(a) Employee choice among high quality plans;

"(b) A competitive marketplace;

"(c) Plan performance and information;

"(d) Employer flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) The improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

"(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members.

"(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

"(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

"(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and

their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

"(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(8) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

"(9) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

"**SECTION 4.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is amended to read:

"243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

"(a) Employee choice among high quality plans;

"(b) A competitive marketplace;

"(c) Plan performance and information;

"(d) Employer flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) The improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

"(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members who are not enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

"(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

"(5) In developing any health benefit plan, the board may provide an option of additional cov-

erage for eligible employees and their family members at an additional cost or premium.

"(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

"(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year.

"(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

"(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

"(10) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

"(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

"**SECTION 5.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and section 27, chapter 746, Oregon Laws 2017, is amended to read:

"243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state and the local governments. In considering whether to enter into a contract for a plan, the board shall place emphasis on:

"(a) Employee choice among high quality plans;

"(b) A competitive marketplace;

"(c) Plan performance and information;

"(d) Employer flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) The improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of plan contracted for and offered but the number of carriers shall be held to a number consistent with adequate service to eligible employees and their family members.

"(3) Where appropriate for a contracted and offered health benefit plan, the board shall provide

options under which an eligible employee may arrange coverage for family members who are not enrolled in another health benefit plan offered by the board or the Oregon Educators Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board may not be paid the employer contribution for the plan that was declined.

"(4) Payroll deductions for costs that are not payable by the state or a local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the plan or plans selected and the deduction of a certain sum from the employee's pay.

"(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and their family members at an additional cost or premium.

"(6) Transfer of enrollment from one plan to another shall be open to all eligible employees and their family members under rules adopted by the board. Because of the special problems that may arise in individual instances under comprehensive group practice plan coverage involving acceptable provider-patient relations between a particular panel of providers and particular eligible employees and their family members, the board shall provide a procedure under which any eligible employee may apply at any time to substitute a health service benefit plan for participation in a comprehensive group practice benefit plan.

"(7) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(8)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year.

"(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

"(9) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

"(10) If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year.

"(11) No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (10) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care.

"**SECTION 6.** ORS 243.866 is amended to read:

"243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

"(a) Employee choice among high-quality plans;

"(b) Encouragement of a competitive marketplace;

"(c) Plan performance and information;

"(d) District and local government flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) Improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members.

"(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

"(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

"(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

"(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

"(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.

"(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(9) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

"(10) No later than February 1 of each year, the board shall report to the Legislative Assembly on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care.

"**SECTION 7.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is amended to read:

"243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

"(a) Employee choice among high-quality plans;

"(b) Encouragement of a competitive marketplace;

"(c) Plan performance and information;

"(d) District and local government flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) Improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members who are not enrolled in another health benefit plan offered by the board or the Public Employees' Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board may not be paid the employer contribution for the plan that was declined.

"(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

"(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

"(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

"(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

"(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.

"(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(9)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year.

"(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

"(10) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

"(11) By January 1, 2023, the board shall spend at least 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care.

"(12) No later than February 1 of each year, the board shall report to the Legislative Assembly

on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care.

"**SECTION 8.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and section 28, chapter 746, Oregon Laws 2017, is amended to read:

"243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed to meet the needs and provide for the welfare of eligible employees, the districts and local governments. In considering whether to enter into a contract for a benefit plan, the board shall place emphasis on:

"(a) Employee choice among high-quality plans;

"(b) Encouragement of a competitive marketplace;

"(c) Plan performance and information;

"(d) District and local government flexibility in plan design and contracting;

"(e) Quality customer service;

"(f) Creativity and innovation;

"(g) Plan benefits as part of total employee compensation;

"(h) Improvement of employee health; and

"(i) [*Health outcome and quality measures*] **Measures of health outcomes and health care quality**, described in ORS 413.017 (4), that are reported by the plan.

"(2) The board may approve more than one carrier for each type of benefit plan offered, but the board shall limit the number of carriers to a number consistent with adequate service to eligible employees and family members who are not enrolled in another health benefit plan offered by the board or the Public Employees' Benefit Board. An eligible employee who declines coverage in a health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board and who is enrolled as a spouse or family member in another health benefit plan offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board may not be paid the employer contribution for the plan that was declined.

"(3) When appropriate, the board shall provide options under which an eligible employee may arrange coverage for family members under a benefit plan.

"(4) A district or a local government shall provide that payroll deductions for benefit plan costs that are not payable by the district or local government may be made upon receipt of a signed authorization from the employee indicating an election to participate in the benefit plan or plans selected and allowing the deduction of those costs from the employee's pay.

"(5) In developing any benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional premium.

"(6) The board shall adopt rules providing that transfer of enrollment from one benefit plan to another is open to all eligible employees and family members. Because of the special problems that may arise involving acceptable provider-patient relations between a particular panel of providers and a particular eligible employee or family member under a comprehensive group practice benefit plan, the board shall provide a procedure under which any eligible employee may apply at any time to substitute another benefit plan for participation in a comprehensive group practice benefit plan.

"(7) An eligible employee who is retired is not required to participate in a health benefit plan offered under this section in order to obtain dental benefit plan coverage. The board shall establish by rule standards of eligibility for retired employees to participate in a dental benefit plan.

"(8) The board shall evaluate a benefit plan that serves a limited geographic region of this state according to the criteria described in subsection (1) of this section.

"(9)(a) The board shall use payment methodologies in self-insured health benefit plans offered by the board that are designed to limit the growth in per-member expenditures for health services to no more than 3.4 percent per year.

"(b) The board shall adopt policies and practices designed to limit the annual increase in premium amounts paid for contracted health benefit plans to 3.4 percent.

"(10) A carrier or third party administrator that contracts with the board to provide or administer a health benefit plan shall, at least once each plan year, conduct an audit of the health benefit plan enrollees' continued eligibility for coverage as spouses or dependents or any other basis that would affect the cost of the premium for the plan.

"(11) If the board spends less than 12 percent of its total medical expenditures in self-insured health benefit plans on payments for primary care, the board shall implement a plan for increasing the percentage of total medical expenditures spent on payments for primary care by at least one percent each year.

"(12) No later than February 1 of each year, the board shall report to the Legislative Assembly on any plan implemented under subsection (11) of this section and on the board's progress toward achieving the target of spending at least 12 percent of total medical expenditures on payments for primary care.

"**SECTION 9.** ORS 413.032 is amended to read:

"413.032. (1) The Oregon Health Authority is established. The authority shall:

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

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

"(c) Administer the Oregon Prescription Drug Program;

"(d) Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

"(e) Develop the policies for and the provision of mental health treatment and treatment of addictions;

"(f) Assess, promote and protect the health of the public as specified by state and federal law;

"(g) 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;

"(h) 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;

"(i) 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;

"(j) 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;

"(k) 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;

"(L) 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;

"(m) Develop, in consultation with the Department of Consumer and Business Services, one or more products designed to provide more affordable options for the small group market;

"(n) Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4); and

"(o) Implement a process for collecting the health outcome and quality measure data identified by the Health [*Plan*] Quality Metrics Committee and report the data to the Oregon Health Policy Board.

"(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.

"(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 413.042 and 741.340 or by other statutes.

"**SECTION 10.** ORS 414.025 is amended to read:

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

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

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

"(A) Shared savings arrangements;

"(B) Bundled payments; and

"(C) Payments based on episodes.

"(2) 'Behavioral health assessment' means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

"(3) 'Behavioral health clinician' means:

"(a) A licensed psychiatrist;

"(b) A licensed psychologist;

"(c) A certified nurse practitioner with a specialty in psychiatric mental health;

"(d) A licensed clinical social worker;

"(e) A licensed professional counselor or licensed marriage and family therapist;

"(f) A certified clinical social work associate;

"(g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or

"(h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

"(4) 'Behavioral health crisis' means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

"(5) 'Behavioral health home' means a mental health disorder or substance use disorder treatment organization, as defined by the Oregon Health Authority by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

"(6) 'Category of aid' means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security Income payments.

"(7) 'Community health worker' means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

"(a) Has expertise or experience in public health;

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

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

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

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

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

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

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

"(8) 'Coordinated care organization' means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.625.

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

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

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

"(10)(a) 'Family support specialist' means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

"(A) Is a current or former consumer of mental health or addiction treatment; or

"(B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

"(b) A 'family support specialist' may be a peer wellness specialist or a peer support specialist.

"(11) 'Global budget' means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to

and quality of the health care delivered to members of the coordinated care organization.

"(12) 'Health insurance exchange' or 'exchange' means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

"(13) 'Health services' means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized list of health services compiled by the Health Evidence Review Commission under ORS 414.690:

"(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, a behavioral health clinician or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

"(c) Prescription drugs;

"(d) Laboratory and X-ray services;

"(e) Medical equipment and supplies;

"(f) Mental health services;

"(g) Chemical dependency services;

"(h) Emergency dental services;

"(i) Nonemergency dental services;

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

"(k) Emergency hospital services;

"(L) Outpatient hospital services; and

"(m) Inpatient hospital services.

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

"(15)(a) 'Integrated health care' means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

"(A) Mental illness.

"(B) Substance use disorders.

"(C) Health behaviors that contribute to chronic illness.

"(D) Life stressors and crises.

"(E) Developmental risks and conditions.

"(F) Stress-related physical symptoms.

"(G) Preventive care.

"(H) Ineffective patterns of health care utilization.

"(b) As used in this subsection, 'other care team members' includes but is not limited to:

"(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the Oregon Health Authority by rule;

"(B) Peer wellness specialists;

"(C) Peer support specialists;

"(D) Community health workers who have completed a state-certified training program;

"(E) Personal health navigators; or

"(F) Other qualified individuals approved by the Oregon Health Authority.

"(16) '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 or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

"(17) 'Medical assistance' means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance and 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.

"(18) '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. Except as provided in ORS 411.439 and 411.447, 'medical assistance' does not include care or services for a resident of a nonmedical public institution.

"(19) '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 ORS 414.655 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.

"(20) 'Peer support specialist' means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

"(a) An individual who is a current or former consumer of mental health treatment; or

"(b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from an addiction disorder.

"(21) 'Peer wellness specialist' means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

"(22) 'Person centered care' means care that:

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

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

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

"(23) 'Personal health navigator' means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and 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.

"(24) 'Prepaid managed care health services organization' means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

"(25) 'Quality measure' means the [*health outcome and quality measures*] **measures of health outcomes and health care quality** and benchmarks identified by the Health [*Plan*] Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 414.638.

"(26) '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.

"(27)(a) 'Youth support specialist' means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

"(A) Is not older than 30 years of age; and

"(B)(i) Is a current or former consumer of mental health or addiction treatment; or

"(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

"(b) A 'youth support specialist' may be a peer wellness specialist or a peer support specialist.

"**SECTION 11.** ORS 414.065 is amended to read:

"414.065. (1)(a) With respect to health care and services to be provided in medical assistance during any period, the Oregon Health Authority shall determine, subject to such revisions as it may make from time to time and subject to legislative funding and paragraph (b) of this subsection:

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

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

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

"(D) Reasonable fees, charges, daily rates and global payments for meeting the costs of providing health services to an applicant or recipient.

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

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

"(b) The authority shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

"(2) The types and extent of 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 medical assistance funds available to providers of 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 health care and services for which such payments

of medical assistance were made.

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

"(5) In determining a global budget for a coordinated care organization:

"(a) The allocation of the payment, the risk and any cost savings shall be determined by the governing body of the organization;

"(b) The authority shall consider the community health assessment conducted by the organization and reviewed annually, and the organization's health care costs; and

"(c) The authority shall take into account the organization's provision of innovative, nontraditional health services.

"(6) Under the supervision of the Governor, the authority may work with the Centers for Medicare and Medicaid Services to develop, in addition to global budgets, payment streams:

"(a) To support improved delivery of health care to recipients of medical assistance; and

"(b) That are funded by coordinated care organizations, counties or other entities other than the state whose contributions qualify for federal matching funds under Title XIX or XXI of the Social Security Act.

"**SECTION 12.** ORS 414.625, as amended by section 3, chapter 49, Oregon Laws 2018, is amended to read:

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

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

"(b) Meet the following minimum financial requirements:

"(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

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

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

"(c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except

for expenditures on prescription drugs, vision care and dental care.

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

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

"(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

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

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

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

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

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

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

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

"(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

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

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

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

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

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

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

"(E) Include providers of specialty care.

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

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

"(L) Each coordinated care organization reports on [*outcome and quality measures*] **measures of health outcomes and health care quality** adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

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

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

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

"(A) At least one member representing persons that share in the financial risk of the organization;

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

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

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

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

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

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

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

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

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

"(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

"(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care

organization in the area where they reside.

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

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

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

"(b) Meet the following minimum financial requirements:

"(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

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

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

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

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

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

"(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

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

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

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

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

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

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

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

"(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

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

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

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

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

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

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

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

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

"(E) Include providers of specialty care.

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

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

"(L) Each coordinated care organization reports on [*outcome and quality measures*] **measures of health outcomes and health care quality** adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.464 and 442.466.

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

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

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

"(A) At least one member representing persons that share in the financial risk of the organization;

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

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

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

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

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

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

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

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

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

"(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

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

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

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

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

"**SECTION 14.** ORS 414.638 is amended to read:

"414.638. (1) There is created in the Health [*Plan*] Quality Metrics Committee a nine-member metrics and scoring subcommittee appointed by the Director of the Oregon Health Authority. The members of the subcommittee serve two-year terms and must include:

"(a) Three members at large;

"(b) Three individuals with expertise in health outcomes measures; and

"(c) Three representatives of coordinated care organizations.

"(2) The subcommittee shall select, from the [*health outcome and quality measures*] **measures of health outcomes and health care quality** identified by the Health [*Plan*] Quality Metrics Committee, the [*health outcome and quality measures*] **measures of health outcomes and health care quality** applicable to services provided by coordinated care organizations. The Oregon Health Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

"(3) The subcommittee shall evaluate the [*health outcome and quality measures*] **measures of health outcomes and health care quality** annually, reporting recommendations based on its findings to the Health [*Plan*] Quality Metrics Committee, and adjust the measures to reflect:

"(a) The amount of the global budget for a coordinated care organization;

"(b) Changes in membership of the organization;

"(c) The organization's costs for implementing [*outcome and quality measures*] **measures of health outcomes and health care quality**; and

"(d) The community health assessment and the costs of the community health assessment conducted by the organization under ORS 414.627.

"(4) The authority shall evaluate on a regular and ongoing basis the [*outcome and quality measures*] **measures of health outcomes and health care quality** selected by the subcommittee under this section for members in each coordinated care organization and for members statewide.

"**SECTION 15.** ORS 414.652, as amended by section 5, chapter 49, Oregon Laws 2018, is amended to read:

"414.652. (1) As used in this section:

"(a) 'Benefit period' means a period of time, shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

"(b) 'Renew' means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

"(2) A contract entered into between the authority and a coordinated care organization under ORS 414.625 (1):

"(a) Shall be for a term of five years;

"(b) Except as provided in subsection (4) of this section, may not be amended more than once in each 12-month period; and

"(c) May be terminated by the authority if a coordinated care organization fails to meet [*outcome and quality measures*] **measures of health outcomes and health care quality** specified in the contract or is otherwise in breach of the contract.

"(3) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet [*outcome and quality measures*] **measures of health outcomes and health care quality** specified in the contract prior to the termination of the contract.

"(4) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

"(a) The authority and the coordinated care organization mutually agree to amend the contract; or

"(b) Amendments are necessitated by changes in federal or state law.

"(5) Except as provided in subsection (7) of this section, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization.

"(6) An amendment to a contract may apply retroactively only if:

"(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

"(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid

Services.

"(7) No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

"(8) A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection (7) of this section. Except as provided in subsections (9) and (10) of this section, a refusal to renew terminates the contract at the end of the benefit period.

"(9) The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

"(a) Notified each of its members and contracted providers of the termination of the contract;

"(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

"(c) Provided to the authority a plan for closing out its coordinated care organization business.

"(10) The authority may waive compliance with the deadlines in subsections (8) and (9) of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

"**SECTION 16.** ORS 414.652, as amended by section 5, chapter 49, Oregon Laws 2018, is amended to read:

"414.652. (1) As used in this section:

"(a) 'Benefit period' means a period of time, shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

"(b) 'Renew' means an agreement by a coordinated care organization to amend the terms or conditions of an existing contract for the next benefit period.

"(2) A contract entered into between the authority and a coordinated care organization under ORS 414.625 (1):

"(a) Shall be for a term of five years;

"(b) Except as provided in subsection (4) of this section, may not be amended more than once in each 12-month period; and

"(c) May be terminated by the authority if a coordinated care organization fails to meet [*outcome and quality measures*] **measures of health outcomes and health care quality** specified in the contract or is otherwise in breach of the contract.

"(3) This section does not prohibit the authority from allowing a coordinated care organization a reasonable amount of time in which to cure any failure to meet [*outcome and quality measures*] **measures of health outcomes and health care quality** specified in the contract prior to the termination of the contract.

"(4) A contract entered into between the authority and a coordinated care organization may be amended more than once in each 12-month period if:

"(a) The authority and the coordinated care organization mutually agree to amend the contract; or

"(b) Amendments are necessitated by changes in federal or state law.

"(5) Except as provided in subsection (7) of this section, the authority must give a coordinated care organization at least 60 days' advance notice of any amendments the authority proposes to existing contracts between the authority and the coordinated care organization.

"(6) An amendment to a contract may apply retroactively only if:

"(a) The amendment does not result in a claim by the authority for the recovery of amounts paid by the authority to the coordinated care organization prior to the date of the amendment; or

"(b) The Centers for Medicare and Medicaid Services notifies the authority, in writing, that the amendment is a condition for approval of the contract by the Centers for Medicare and Medicaid Services.

"(7) No later than 134 days prior to the end of a benefit period, the authority shall provide to each coordinated care organization notice of the proposed changes to the terms and conditions of a contract, as will be submitted to the Centers for Medicare and Medicaid Services for approval, for the next benefit period.

"(8) A coordinated care organization must notify the authority of the coordinated care organization's refusal to renew a contract with the authority no later than 14 days after the authority provides the notice described in subsection (7) of this section. Except as provided in subsections (9) and (10) of this section, a refusal to renew terminates the contract at the end of the benefit period.

"(9) The authority may require a contract to remain in force into the next benefit period and be amended as proposed by the authority until 90 days after the coordinated care organization has, in accordance with criteria prescribed by the authority:

"(a) Notified each of its members and contracted providers of the termination of the contract;

"(b) Provided to the authority a plan to transition its members to another coordinated care organization; and

"(c) Provided to the authority a plan for closing out its coordinated care organization business.

"(10) The authority may waive compliance with the deadlines in subsections (8) and (9) of this section if the Director of the Oregon Health Authority finds that the waiver of the deadlines is consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

"**SECTION 17.** ORS 417.721 is amended to read:

"417.721. The Oregon Health Authority, the Health [*Plan*] Quality Metrics Committee and the Early Learning Council shall work collaboratively with coordinated care organizations to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes.

"**SECTION 18.** Section 1, chapter 389, Oregon Laws 2015, is amended to read:

"**Sec. 1.** (1) The Oregon Health Policy Board, in consultation with the Public Employees' Benefit Board, the Oregon Educators Benefit Board, the Oregon Health Authority and the Department of Consumer and Business Services shall develop a statewide strategic plan for the collection and use of health care data. The plan must:

"(a) Include clear objectives for how health care data will be used, and what types of data are needed, in state health care programs to support health system transformation efforts and promote value;

"(b) Allow for alignment of performance metrics across state health care programs;

"(c) Ensure that the state's efforts in the collection and use of health care data encourage in-

tegrated and coordinated care, promote improved quality, health outcomes and patient satisfaction and help reduce costs;

"(d) Include strategies to ensure that the state's collection, use and measurement of health care data advance payment reform and allow for alternative payment methodologies;

"(e) To the extent practicable, allow for alternative reporting and measurement mechanisms that are not claims-based or that are for payers and providers who are moving away from fee-for-service based reimbursement;

"(f) Identify appropriate and inappropriate uses of health care data, including safeguards to ensure privacy and ensure that data is not used for marketing or other inappropriate purposes; and

"(g) Outline a five-year vision including implementation timelines in sufficient detail that health care stakeholders can plan for expected new data reporting requirements and uses.

"(2) The Oregon Health Policy Board shall submit the plan developed under subsection (1) of this section to the interim committees of the Legislative Assembly related to health care no later than September 1, 2016.

"(3) The performance measures developed by the Health [*Plan*] Quality Metrics Committee established under ORS 413.017 (4) must be aligned with the statewide strategic plan adopted under this section.

"**SECTION 19.** Section 3, chapter 389, Oregon Laws 2015, is amended to read:

"**Sec. 3.** The Oregon Health Authority shall submit two reports to the Legislative Assembly, in the manner provided in ORS 192.245, on the activities of the Health [*Plan*] Quality Metrics Committee and the authority in complying with the provisions of ORS 413.017 (4)(b) to (f). The first report shall be submitted during the 2017 regular session of the Legislative Assembly. A second report shall be submitted during the 2019 regular session of the Legislative Assembly.

"**SECTION 20.** Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chapter 384, Oregon Laws 2017, and section 13, chapter 489, Oregon Laws 2017, is amended to read:

"**Sec. 2.** (1) As used in this section:

"(a) 'Carrier' means an insurer that offers a health benefit plan, as defined in ORS 743B.005.

"(b) 'Coordinated care organization' has the meaning given that term in ORS 414.025.

"(c) 'Primary care' means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

"(d) 'Primary care provider' includes:

"(A) A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care.

"(B) A health care team or clinic that has been certified by the Oregon Health Authority as a patient centered primary care home.

"(2)(a) The Oregon Health Authority shall convene a primary care payment reform collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative to:

"(A) Use value-based payment methods that are not paid on a per claim basis to:

"(i) Increase the investment in primary care;

"(ii) Align primary care reimbursement by all purchasers of care; and

"(iii) Continue to improve reimbursement methods, including by investing in the social determinants of health;

"(B) Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care;

"(C) Provide technical assistance to clinics and payers in implementing the initiative;

"(D) Aggregate the data from and align the metrics used in the initiative with the work of the Health [*Plan*] Quality Metrics Committee established in ORS 413.017;

"(E) Facilitate the integration of primary care behavioral and physical health care; and

"(F) Ensure that the goals of the initiative are met by December 31, 2027.

"(b) The collaborative is a governing body, as defined in ORS 192.610.

"(3) The authority shall invite representatives from all of the following to participate in the primary care payment reform collaborative:

"(a) Primary care providers;

"(b) Health care consumers;

"(c) Experts in primary care contracting and reimbursement;

"(d) Independent practice associations;

"(e) Behavioral health treatment providers;

"(f) Third party administrators;

"(g) Employers that offer self-insured health benefit plans;

"(h) The Department of Consumer and Business Services;

"(i) Carriers;

"(j) A statewide organization for mental health professionals who provide primary care;

"(k) A statewide organization representing federally qualified health centers;

"(L) A statewide organization representing hospitals and health systems;

"(m) A statewide professional association for family physicians;

"(n) A statewide professional association for physicians;

"(o) A statewide professional association for nurses; and

"(p) The Centers for Medicare and Medicaid Services.

"(4) The primary care payment reform collaborative shall annually report to the Oregon Health Policy Board and to the Legislative Assembly on the achievement of the primary care spending targets in ORS 414.625 and 743.010 and the implementation of the Primary Care Transformation Initiative.

"(5) A coordinated care organization shall report to the authority, no later than October 1 of each year, the proportion of the organization's total medical costs that are allocated to primary care.

"(6) The authority, in collaboration with the Department of Consumer and Business Services, shall adopt rules prescribing the primary care services for which costs must be reported under subsection (5) of this section.".
