

A-Engrossed Senate Bill 765

Ordered by the Senate April 15
Including Senate Amendments dated April 15

Sponsored by Senators STEINER HAYWARD, BEYER, Representative NOBLE; Senators FREDERICK, HEARD, MONNES ANDERSON, WINTERS, Representatives PRUSAK, SALINAS (at the request of Sam Barber, Lobby Oregon, American Academy of Family Physicians)

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.

Modifies definitions of "primary care" and "total medical expenditures" for purpose of reports on spending for primary care by insurance carriers, Public Employees' Benefit Board, Oregon Educators Benefit Board and coordinated care organizations. Requires *[all]* carriers, *[providing specified health insurance]* **Public Employees' Benefit Board, Oregon Educators Benefit Board and coordinated care organizations** to report on spending **anticipated in upcoming year** on primary care, *[and]* on use of alternative payment methodologies for reimbursing costs of primary care **and on percentage of spending on primary care that uses alternative payment methodologies**.

Requires Department of Consumer and Business Services and Oregon Health Authority to prescribe by rule percentage of primary care expenditures that must be reimbursed using alternative payment methodologies.

A BILL FOR AN ACT

1
2 Relating to primary care; creating new provisions; amending ORS 243.105, 243.107, 243.135, 243.860,
3 243.866, 279A.025, 414.625, 414.653 and 743.010 and sections 1, 2, 3 and 5, chapter 575, Oregon
4 Laws 2015, and sections 3 and 20, chapter 489, Oregon Laws 2017; and repealing ORS 743B.458.

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

6 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS chapter 413.**

7 **SECTION 2. (1) As used in this section:**

8 (a) "Behavioral health clinician" means:

9 (A) A psychiatrist;

10 (B) A psychologist licensed under ORS 675.010 to 675.150;

11 (C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-
12 chiatric mental health;

13 (D) A clinical social worker licensed under ORS 675.530;

14 (E) A marriage and family therapist or professional counselor licensed under ORS
15 675.715;

16 (F) A clinical social work associate certified under ORS 675.537; or

17 (G) An intern or resident who is working under a board-approved supervisory contract
18 in a clinical mental health field.

19 (b) "Primary care" means family medicine, general internal medicine, naturopathic
20 medicine, pediatrics and care provided by primary care integrated behavioral health
21 clinicians or primary care integrated women's health clinicians.

22 (c) "Primary care integrated behavioral health clinician" means:

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 (A) A care team member as defined in ORS 414.025 (15)(b); or
2 (B) A behavioral health clinician providing care to individuals and families in a patient
3 centered primary care home to address one or more of the following:
4 (i) Mental illness.
5 (ii) Substance use disorders.
6 (iii) Health behaviors that contribute to chronic illness.
7 (iv) Life stressors and crises.
8 (v) Developmental risks and conditions.
9 (vi) Stress-related physical symptoms.
10 (vii) Preventive care.
11 (viii) Ineffective patterns of health care utilization.
- 12 (d) “Primary care integrated women’s health clinician” means one of the following
13 clinicians whose practice is focused on women’s health and primary care and who provides
14 a range of the services within a patient centered primary care home:
15 (A) A physician who is an obstetrician or gynecologist;
16 (B) A nurse practitioner;
17 (C) A physician assistant; or
18 (D) Another health professional licensed or certified in this state.
- 19 (e) “Total medical expenditures” means total expenditures for physical and mental health
20 care provided to members of a coordinated care organization, excluding expenditures for vi-
21 sion care and dental care.
- 22 (2) No later than January 1, 2023, a coordinated care organization must spend at least
23 12 percent of the coordinated care organization’s total medical expenditures on primary care.
- 24 (3) No later than January 1, 2020, a coordinated care organization must reimburse a
25 percentage, as established by the Oregon Health Authority by rule, of all primary care costs
26 using alternative payment methodologies.
- 27 (4) After the Oregon Health Authority has established a global budget for a coordinated
28 care organization for a calendar year, the coordinated care organization shall report to the
29 authority, at the time and in the manner prescribed by the authority by rule:
- 30 (a) The percentage of the global budget that the coordinated care organization anticipates
31 spending on primary care in the calendar year;
- 32 (b) The percentage of the spending on primary care that will be in the form of alternative
33 payment methodologies in the calendar year; and
- 34 (c) The types of alternative payment methodologies that the coordinated care organiza-
35 tion will use during the calendar year.
- 36 **SECTION 3.** ORS 243.105 is amended to read:
37 243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:
38 (1) “Behavioral health clinician” means:
39 (a) A psychiatrist;
40 (b) A psychologist licensed under ORS 675.010 to 675.150;
41 (c) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-
42 chiatric mental health;
43 (d) A clinical social worker licensed under ORS 675.530;
44 (e) A marriage and family therapist or professional counselor licensed under ORS 675.715;
45 (f) A clinical social work associate certified under ORS 675.537; or

1 **(g) An intern or resident who is working under a board-approved supervisory contract in**
2 **a clinical mental health field.**

3 [(1)] **(2)** “Benefit plan” includes, but is not limited to:

4 (a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and
5 other health care recognized by state law, and related services and supplies;

6 (b) Comparable benefits for employees who rely on spiritual means of healing; and

7 (c) Self-insurance programs managed by the Public Employees’ Benefit Board.

8 [(2)] **(3)** “Board” means the Public Employees’ Benefit Board.

9 [(3)] **(4)** “Carrier” means an insurance company or health care service contractor holding a valid
10 certificate of authority from the Director of the Department of Consumer and Business Services, or
11 two or more companies or contractors acting together pursuant to a joint venture, partnership or
12 other joint means of operation, or a board-approved guarantor of benefit plan coverage and com-
13 pensation.

14 [(4)(a)] **(5)(a)** “Eligible employee” means an officer or employee of a state agency or local gov-
15 ernment who elects to participate in one of the group benefit plans described in ORS 243.135. The
16 term includes, but is not limited to, state officers and employees in the exempt, unclassified and
17 classified service, and state officers and employees, whether or not retired, who:

18 (A) Are receiving a service retirement allowance, a disability retirement allowance or a pension
19 under the Public Employees Retirement System or are receiving a service retirement allowance, a
20 disability retirement allowance or a pension under any other retirement or disability benefit plan
21 or system offered by the State of Oregon for its officers and employees;

22 (B) Are eligible to receive a service retirement allowance under the Public Employees Retire-
23 ment System and have reached earliest retirement age under ORS chapter 238;

24 (C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached earliest
25 retirement age as described in ORS 238A.165; or

26 (D) Are eligible to receive a service retirement allowance or pension under another retirement
27 benefit plan or system offered by the State of Oregon and have attained earliest retirement age
28 under the plan or system.

29 (b) “Eligible employee” does not include individuals:

30 (A) Engaged as independent contractors;

31 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

32 (C) Who are employed on less than half-time basis unless the individuals are employed in posi-
33 tions classified as job-sharing positions, unless the individuals are defined as eligible under rules of
34 the board;

35 (D) Appointed under ORS 240.309;

36 (E) Provided sheltered employment or make-work by the state in an employment or industries
37 program maintained for the benefit of such individuals;

38 (F) Provided student health care services in conjunction with their enrollment as students at a
39 public university listed in ORS 352.002; or

40 (G) Who are members of a collective bargaining unit that represents police officers or fire-
41 fighters.

42 [(5)] **(6)** “Family member” means an eligible employee’s spouse and any unmarried child or
43 stepchild within age limits and other conditions imposed by the board with regard to unmarried
44 children or stepchildren.

45 [(6)] **(7)** “Local government” means any city, county or special district in this state or any

1 intergovernmental entity created under ORS chapter 190.

2 **(8) “Patient centered primary care home” has the meaning given that term in ORS**
3 **414.025.**

4 [(7)] **(9) “Payroll disbursing officer” means the officer or official authorized to disburse moneys**
5 **in payment of salaries and wages of employees of a state agency or local government.**

6 [(8)] **(10) “Premium” means the monthly or other periodic charge for a benefit plan.**

7 [(9)] **(11) “Primary care” means family medicine, general internal medicine, naturopathic medi-**
8 **cine, [obstetrics and gynecology,] pediatrics [or general psychiatry.] and care provided by primary**
9 **care integrated behavioral health clinicians or primary care integrated women’s health**
10 **clinicians.**

11 **(12) “Primary care integrated behavioral health clinician” means:**

12 **(a) A care team member as defined in ORS 414.025 (15)(b); or**

13 **(b) A behavioral health clinician providing care to individuals and families in a patient**
14 **centered primary care home to address one or more of the following:**

15 **(A) Mental illness.**

16 **(B) Substance use disorders.**

17 **(C) Health behaviors that contribute to chronic illness.**

18 **(D) Life stressors and crises.**

19 **(E) Developmental risks and conditions.**

20 **(F) Stress-related physical symptoms.**

21 **(G) Preventive care.**

22 **(H) Ineffective patterns of health care utilization.**

23 **(13) “Primary care integrated women’s health clinician” means one of the following**
24 **clinicians whose practice is focused on women’s health and primary care and who provides**
25 **a range of the services within a patient centered primary care home:**

26 **(a) A physician who is an obstetrician or gynecologist;**

27 **(b) A nurse practitioner;**

28 **(c) A physician assistant; or**

29 **(d) Another health professional licensed or certified in this state.**

30 [(10)] **(14) “State agency” means every state officer, board, commission, department or other**
31 **activity of state government.**

32 [(11)] **(15) “Total medical expenditures” means payments to reimburse the cost of physical and**
33 **mental health care provided to eligible employees or their family members, excluding [prescription**
34 **drugs,] vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated**
35 **rate or other type of payment mechanism.**

36 **SECTION 3a.** ORS 243.107 is amended to read:

37 243.107. A person employed by a public university listed in ORS 352.002 or the Oregon Health
38 and Science University may be considered an eligible employee for participation in one of the group
39 benefit plans described in ORS 243.135 if the governing board of the public university, or the Oregon
40 Health and Science University Board of Directors for Oregon Health and Science University em-
41 ployees, determines that funds are available therefor and if:

42 (1) Notwithstanding ORS 243.105 [(4)(b)(F)] **(5)(b)(F)**, the person is a student enrolled in an in-
43 stitution of higher education and is employed as a graduate teaching assistant, graduate research
44 assistant or a fellow at the institution and elects to participate; or

45 (2) Notwithstanding ORS 243.105 [(4)(b)(B)] **(5)(b)(B)** or (C), the person is employed on a less

1 than half-time basis in an unclassified instructional or research support capacity and elects to par-
2 ticipate.

3 **SECTION 4.** ORS 243.135 is amended to read:

4 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
5 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
6 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
7 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
8 on:

9 (a) Employee choice among high quality plans;

10 (b) A competitive marketplace;

11 (c) Plan performance and information;

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

13 (e) Quality customer service;

14 (f) Creativity and innovation;

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

16 (h) The improvement of employee health; and

17 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
18 plan.

19 (2) The board may approve more than one carrier for each type of plan contracted for and of-
20 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
21 gible employees and their family members.

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

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

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

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

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

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

40 **(9) By January 1, 2020, the board shall reimburse a percentage, as established by rule by**
41 **the Oregon Health Authority in collaboration with the Department of Consumer and Busi-**
42 **ness Services, of all primary care costs in self-insured health benefit plans offered to eligible**
43 **employees using alternative payment methodologies, as defined in ORS 414.025.**

44 **(10) No later than December 1 of each calendar year, the board shall report to the au-**
45 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**

1 **the next calendar year:**

2 (a) **The percentage of total medical expenditures that the board anticipates spending on**
3 **primary care;**

4 (b) **The percentage of spending on primary care that will be in the form of alternative**
5 **payment methodologies; and**

6 (c) **The types of alternative payment methodologies that will be used to reimburse health**
7 **care providers.**

8 [(9)] (11) No later than February 1 of each year, the board shall report to the Legislative As-
9 sembly on the board's progress toward achieving the [*target of spending at least 12 percent of total*
10 *medical expenditures in self-insured health benefit plans on payments for primary care*] **spending**
11 **targets described in subsection (8) of this section and the board's plan for achieving the**
12 **targets.**

13 **SECTION 5.** ORS 243.135, as amended by section 27, chapter 746, Oregon Laws 2017, is
14 amended to read:

15 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
16 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
17 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
18 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
19 on:

20 (a) Employee choice among high quality plans;

21 (b) A competitive marketplace;

22 (c) Plan performance and information;

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

24 (e) Quality customer service;

25 (f) Creativity and innovation;

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

27 (h) The improvement of employee health; and

28 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
29 plan.

30 (2) The board may approve more than one carrier for each type of plan contracted for and of-
31 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
32 gible employees and their family members.

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

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

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

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

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

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

13 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
14 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

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

21 **(11) By January 1, 2020, the board shall reimburse a percentage, as established by rule**
22 **by the Oregon Health Authority in collaboration with the Department of Consumer and**
23 **Business Services, of all primary care costs in self-insured health benefit plans offered to**
24 **eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

25 **(12) No later than December 1 of each calendar year, the board shall report to the au-**
26 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
27 **the next calendar year:**

28 **(a) The percentage of total medical expenditures that the board anticipates spending on**
29 **primary care;**

30 **(b) The percentage of spending on primary care that will be in the form of alternative**
31 **payment methodologies; and**

32 **(c) The types of alternative payment methodologies that will be used to reimburse health**
33 **care providers.**

34 ~~[(11)]~~ **(13)** No later than February 1 of each year, the board shall report to the Legislative As-
35 sembly on the board's progress toward achieving the ~~[target of spending at least 12 percent of total~~
36 ~~medical expenditures in self-insured health benefit plans on payments for primary care]~~ **spending**
37 **targets described in subsection (10) of this section and the board's plan for achieving the**
38 **targets.**

39 **SECTION 6.** ORS 243.135, as amended by section 16, chapter 489, Oregon Laws 2017, and sec-
40 tion 27, chapter 746, Oregon Laws 2017, is amended to read:

41 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public
42 Employees' Benefit Board, the board shall contract for a health benefit plan or plans best designed
43 to meet the needs and provide for the welfare of eligible employees, the state and the local gov-
44 ernments. In considering whether to enter into a contract for a plan, the board shall place emphasis
45 on:

- 1 (a) Employee choice among high quality plans;
- 2 (b) A competitive marketplace;
- 3 (c) Plan performance and information;
- 4 (d) Employer flexibility in plan design and contracting;
- 5 (e) Quality customer service;
- 6 (f) Creativity and innovation;
- 7 (g) Plan benefits as part of total employee compensation;
- 8 (h) The improvement of employee health; and
- 9 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
10 plan.

11 (2) The board may approve more than one carrier for each type of plan contracted for and of-
12 fered but the number of carriers shall be held to a number consistent with adequate service to eli-
13 gible employees and their family members.

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

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

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

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

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

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

39 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
40 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

45 **(10) The board shall spend at least 12 percent of its total medical expenditures in self-**

1 **insured health benefit plans on payments for primary care.**

2 (11) **The board shall reimburse a percentage, as established by rule by the Oregon Health**
3 **Authority in collaboration with the Department of Consumer and Business Services, of all**
4 **primary care costs in self-insured health benefit plans offered to eligible employees using**
5 **alternative payment methodologies, as defined in ORS 414.025.**

6 (12) **No later than December 1 of each calendar year, the board shall report to the au-**
7 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
8 **the next calendar year:**

9 (a) **The percentage of total medical expenditures that the board anticipates spending on**
10 **primary care;**

11 (b) **The percentage of spending on primary care that will be in the form of alternative**
12 **payment methodologies; and**

13 (c) **The types of alternative payment methodologies that will be used to reimburse health**
14 **care providers.**

15 [(10)] (13) **If the board [spends less than 12 percent of its total medical expenditures in self-insured**
16 **health benefit plans on payments for primary care] fails to meet the financial requirements de-**
17 **scribed in subsection (10) of this section, the board shall implement a plan for increasing, by at**
18 **least one percent each year:**

19 (a) **The percentage of total medical expenditures spent on payments for primary care; and**

20 (b) **The percentage of primary care costs that are reimbursed using alternative payment**
21 **methodologies [by at least one percent each year].**

22 [(11)] (14) **No later than February 1 of each year, the board shall report to the Legislative As-**
23 **sembly on any plan implemented under subsection [(10)] (13) of this section and on the board's**
24 **progress toward achieving the [target of spending at least 12 percent of total medical expenditures in**
25 **self-insured health benefit plans on payments for primary care] financial requirements described in**
26 **subsection (12) of this section.**

27 **SECTION 7.** ORS 243.860 is amended to read:

28 243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

29 (1) **“Behavioral health clinician” means:**

30 (a) **A psychiatrist;**

31 (b) **A psychologist licensed under ORS 675.010 to 675.150;**

32 (c) **A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
33 **chiatric mental health;**

34 (d) **A clinical social worker licensed under ORS 675.530;**

35 (e) **A marriage and family therapist or professional counselor licensed under ORS 675.715;**

36 (f) **A clinical social work associate certified under ORS 675.537; or**

37 (g) **An intern or resident who is working under a board-approved supervisory contract in**
38 **a clinical mental health field.**

39 [(1)] (2) **“Benefit plan” includes but is not limited to:**

40 (a) **Contracts for insurance or other benefits, including medical, dental, vision, life, disability and**
41 **other health care recognized by state law, and related services and supplies;**

42 (b) **Self-insurance programs managed by the Oregon Educators Benefit Board; and**

43 (c) **Comparable benefits for employees who rely on spiritual means of healing.**

44 [(2)] (3) **“Carrier” means an insurance company or health care service contractor holding a valid**
45 **certificate of authority from the Director of the Department of Consumer and Business Services, or**

1 two or more companies or contractors acting together pursuant to a joint venture, partnership or
2 other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage
3 and compensation.

4 [(3)] (4) “District” means a common school district, a union high school district, an education
5 service district, as defined in ORS 334.003, or a community college district, as defined in ORS
6 341.005.

7 [(4)(a)] (5)(a) “Eligible employee” includes:

8 (A) An officer or employee of a district or a local government who elects to participate in one
9 of the benefit plans described in ORS 243.864 to 243.874; and

10 (B) An officer or employee of a district or a local government, whether or not retired, who:

11 (i) Is receiving a service retirement allowance, a disability retirement allowance or a pension
12 under the Public Employees Retirement System or is receiving a service retirement allowance, a
13 disability retirement allowance or a pension under any other retirement or disability benefit plan
14 or system offered by the district or local government for its officers and employees;

15 (ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement
16 System and has reached earliest service retirement age under ORS chapter 238;

17 (iii) Is eligible to receive a pension under ORS 238A.100 to 238A.250 and has reached earliest
18 retirement age as described in ORS 238A.165; or

19 (iv) Is eligible to receive a service retirement allowance or pension under any other retirement
20 benefit plan or system offered by the district or local government and has attained earliest retire-
21 ment age under the plan or system.

22 (b) Except as provided in paragraph (a)(B) of this subsection, “eligible employee” does not in-
23 clude an individual:

24 (A) Engaged as an independent contractor;

25 (B) Whose periods of employment in emergency work are on an intermittent or irregular basis;
26 or

27 (C) Who is employed on less than a half-time basis unless the individual is employed in a posi-
28 tion classified as a job-sharing position or unless the individual is defined as eligible under rules of
29 the Oregon Educators Benefit Board or under a collective bargaining agreement.

30 [(5)] (6) “Family member” means an eligible employee’s spouse or domestic partner and any un-
31 married child or stepchild of an eligible employee within age limits and other conditions imposed
32 by the Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

33 [(6)] (7) “Local government” means any city, county or special district in this state.

34 (8) **“Patient centered primary care home” has the meaning given that term in ORS**
35 **414.025.**

36 [(7)] (9) “Payroll disbursing officer” means the officer or official authorized to disburse moneys
37 in payment of salaries and wages of officers and employees of a district or a local government.

38 [(8)] (10) “Premium” means the monthly or other periodic charge, including administrative fees
39 of the Oregon Educators Benefit Board, for a benefit plan.

40 [(9)] (11) “Primary care” means family medicine, general internal medicine, naturopathic medi-
41 cine, [*obstetrics and gynecology,*] pediatrics [*or general psychiatry.*] **and care provided by primary**
42 **care integrated behavioral health clinicians or primary care integrated women’s health**
43 **clinicians.**

44 (12) **“Primary care integrated behavioral health clinician” means:**

45 (a) **A care team member as defined in ORS 414.025 (15)(b); or**

1 **(b) A behavioral health clinician providing care to individuals and families in a patient**
2 **centered primary care home to address one or more of the following:**

- 3 **(A) Mental illness.**
- 4 **(B) Substance use disorders.**
- 5 **(C) Health behaviors that contribute to chronic illness.**
- 6 **(D) Life stressors and crises.**
- 7 **(E) Developmental risks and conditions.**
- 8 **(F) Stress-related physical symptoms.**
- 9 **(G) Preventive care.**
- 10 **(H) Ineffective patterns of health care utilization.**

11 **(13) “Primary care integrated women’s health clinician” means one of the following**
12 **clinicians whose practice is focused on women’s health and primary care and who provides**
13 **a range of the services within a patient centered primary care home:**

- 14 **(a) A physician who is an obstetrician or gynecologist;**
- 15 **(b) A nurse practitioner;**
- 16 **(c) A physician assistant; or**
- 17 **(d) Another health professional licensed or certified in this state.**

18 [(10)] **(14) “Total medical expenditures” means payments to reimburse the cost of physical and**
19 **mental health care provided to eligible employees or their family members, excluding [prescription**
20 **drugs,] vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated**
21 **rate or other type of payment mechanism.**

22 **SECTION 8. ORS 243.866 is amended to read:**

23 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
24 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
25 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
26 phasis on:

- 27 (a) Employee choice among high-quality plans;
- 28 (b) Encouragement of a competitive marketplace;
- 29 (c) Plan performance and information;
- 30 (d) District and local government flexibility in plan design and contracting;
- 31 (e) Quality customer service;
- 32 (f) Creativity and innovation;
- 33 (g) Plan benefits as part of total employee compensation;
- 34 (h) Improvement of employee health; and
- 35 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
36 plan.

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

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

42 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
43 that are not payable by the district or local government may be made upon receipt of a signed au-
44 thorization from the employee indicating an election to participate in the benefit plan or plans se-
45 lected and allowing the deduction of those costs from the employee’s pay.

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

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

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

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

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

16 **(10) By January 1, 2020, the board shall reimburse a percentage, as established by rule**
17 **by the Oregon Health Authority in collaboration with the Department of Consumer and**
18 **Business Services, of all primary care costs in self-insured health benefit plans offered to**
19 **eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

20 **(11) No later than December 1 of each calendar year, the board shall report to the au-**
21 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
22 **the next calendar year:**

23 **(a) The percentage of total medical expenditures that the board anticipates spending on**
24 **primary care;**

25 **(b) The percentage of spending on primary care that will be in the form of alternative**
26 **payment methodologies; and**

27 **(c) The types of alternative payment methodologies that will be used to reimburse health**
28 **care providers.**

29 [(10)] **(12) No later than February 1 of each year, the board shall report to the Legislative As-**
30 **sembly on the board's progress toward achieving the [target of spending at least 12 percent of total**
31 **medical expenditures on payments for primary care] spending targets described in subsection (9)**
32 **of this section and the board's plan for achieving the targets.**

33 **SECTION 9.** ORS 243.866, as amended by section 28, chapter 746, Oregon Laws 2017, is
34 amended to read:

35 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
36 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
37 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
38 phasis on:

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

40 (b) Encouragement of a competitive marketplace;

41 (c) Plan performance and information;

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

43 (e) Quality customer service;

44 (f) Creativity and innovation;

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

1 (h) Improvement of employee health; and

2 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
3 plan.

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

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

14 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
15 that are not payable by the district or local government may be made upon receipt of a signed au-
16 thorization from the employee indicating an election to participate in the benefit plan or plans se-
17 lected and allowing the deduction of those costs from the employee's pay.

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

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

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

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

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

34 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
35 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

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

42 **(12) By January 1, 2020, the board shall reimburse a percentage, as established by rule**
43 **by the Oregon Health Authority in collaboration with the Department of Consumer and**
44 **Business Services, of all primary care costs in self-insured health benefit plans offered to**
45 **eligible employees using alternative payment methodologies, as defined in ORS 414.025.**

1 **(13) No later than December 1 of each calendar year, the board shall report to the au-**
2 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
3 **the next calendar year:**

4 **(a) The percentage of total medical expenditures that the board anticipates spending on**
5 **primary care;**

6 **(b) The percentage of spending on primary care that will be in the form of alternative**
7 **payment methodologies; and**

8 **(c) The types of alternative payment methodologies that will be used to reimburse health**
9 **care providers.**

10 [(12)] **(14) No later than February 1 of each year, the board shall report to the Legislative As-**
11 **sembly on the board's progress toward achieving the [target of spending at least 12 percent of total**
12 **medical expenditures on payments for primary care] spending targets described in subsection (11)**
13 **of this section and the board's plan for achieving the targets.**

14 **SECTION 10.** ORS 243.866, as amended by section 17, chapter 489, Oregon Laws 2017, and
15 section 28, chapter 746, Oregon Laws 2017, is amended to read:

16 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best designed
17 to meet the needs and provide for the welfare of eligible employees, the districts and local govern-
18 ments. In considering whether to enter into a contract for a benefit plan, the board shall place em-
19 phasis on:

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

21 (b) Encouragement of a competitive marketplace;

22 (c) Plan performance and information;

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

24 (e) Quality customer service;

25 (f) Creativity and innovation;

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

27 (h) Improvement of employee health; and

28 (i) Health outcome and quality measures, described in ORS 413.017 (4), that are reported by the
29 plan.

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

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

40 (4) A district or a local government shall provide that payroll deductions for benefit plan costs
41 that are not payable by the district or local government may be made upon receipt of a signed au-
42 thorization from the employee indicating an election to participate in the benefit plan or plans se-
43 lected and allowing the deduction of those costs from the employee's pay.

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

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

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

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

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

15 (b) The board shall adopt policies and practices designed to limit the annual increase in pre-
16 mium amounts paid for contracted health benefit plans to 3.4 percent.

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

21 **(11) The board shall:**

22 **(a) Spend at least 12 percent of its total medical expenditures in self-insured health ben-**
23 **efit plans on payments for primary care; and**

24 **(b) Reimburse a percentage, as established by rule by the Oregon Health Authority in**
25 **collaboration with the Department of Consumer and Business Services, of all primary care**
26 **costs in self-insured health benefit plans that are offered to eligible employees using alter-**
27 **native payment methodologies, as defined in ORS 414.025.**

28 *[(11)]* **(12) If the board [spends less than 12 percent of its total medical expenditures in self-insured**
29 **health benefit plans on payments for primary care] fails to meet the financial requirements de-**
30 **scribed in subsection (11) of this section, the board shall implement a plan for increasing, by at**
31 **least one percent each year:**

32 **(a) The percentage of total medical expenditures spent on payments for primary care [by at least**
33 **one percent each year]; and**

34 **(b) The percentage of primary care costs that are reimbursed using alternative payment**
35 **methodologies.**

36 **(13) No later than December 1 of each calendar year, the board shall report to the au-**
37 **thority, with respect to the self-insured health benefit plans offered to eligible employees for**
38 **the next calendar year:**

39 **(a) The percentage of total medical expenditures that the board anticipates spending on**
40 **primary care;**

41 **(b) The percentage of spending on primary care that will be in the form of alternative**
42 **payment methodologies; and**

43 **(c) The types of alternative payment methodologies that will be used to reimburse health**
44 **care providers.**

45 *[(12)]* **(14) No later than February 1 of each year, the board shall report to the Legislative As-**

1 sembly on any plan implemented under subsection [(11)] (12) of this section and on the board's
2 progress toward achieving the [target of spending at least 12 percent of total medical expenditures on
3 payments for primary care] **financial requirements described in subsection (11) of this section.**

4 **SECTION 10a.** ORS 279A.025 is amended to read:

5 279A.025. (1) Except as provided in subsections (2) to (4) of this section, the Public Contracting
6 Code applies to all public contracting.

7 (2) The Public Contracting Code does not apply to:

8 (a) Contracts between a contracting agency and:

9 (A) Another contracting agency;

10 (B) The Oregon Health and Science University;

11 (C) A public university listed in ORS 352.002;

12 (D) The Oregon State Bar;

13 (E) A governmental body of another state;

14 (F) The federal government;

15 (G) An American Indian tribe or an agency of an American Indian tribe;

16 (H) A nation, or a governmental body in a nation, other than the United States; or

17 (I) An intergovernmental entity formed between or among:

18 (i) Governmental bodies of this or another state;

19 (ii) The federal government;

20 (iii) An American Indian tribe or an agency of an American Indian tribe;

21 (iv) A nation other than the United States; or

22 (v) A governmental body in a nation other than the United States;

23 (b) Agreements authorized by ORS chapter 190 or by a statute, charter provision, ordinance or
24 other authority for establishing agreements between or among governmental bodies or agencies or
25 tribal governing bodies or agencies;

26 (c) Insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and
27 414.145 for purposes of source selection;

28 (d) Grants;

29 (e) Contracts for professional or expert witnesses or consultants to provide services or testimony
30 relating to existing or potential litigation or legal matters in which a public body is or may become
31 interested;

32 (f) Acquisitions or disposals of real property or interest in real property;

33 (g) Sole-source expenditures when rates are set by law or ordinance for purposes of source se-
34 lection;

35 (h) Contracts for the procurement or distribution of textbooks;

36 (i) Procurements by a contracting agency from an Oregon Corrections Enterprises program;

37 (j) The procurement, transportation, sale or distribution of distilled liquor, as defined in ORS
38 471.001, or the appointment of agents under ORS 471.230 or 471.750 by the Oregon Liquor Control
39 Commission;

40 (k) Contracts entered into under ORS chapter 180 between the Attorney General and private
41 counsel or special legal assistants;

42 (L) Contracts for the sale of timber from lands owned or managed by the State Board of Forestry
43 and the State Forestry Department;

44 (m) Contracts for activities necessary or convenient for the sale of timber under paragraph (L)
45 of this subsection, either separately from or in conjunction with contracts for the sale of timber,

1 including but not limited to activities such as timber harvesting and sorting, transporting, gravel
2 pit development or operation, and road construction, maintenance or improvement;

3 (n) Contracts for forest protection or forest related activities, as described in ORS 477.406, by
4 the State Forester or the State Board of Forestry;

5 (o) Contracts entered into by the Housing and Community Services Department in exercising the
6 department's duties prescribed in ORS chapters 456 and 458, except that the department's public
7 contracting for goods and services is subject to ORS chapter 279B;

8 (p) Contracts entered into by the State Treasurer in exercising the powers of that office pre-
9 scribed in ORS 178.010 to 178.090 and 276A.242 and ORS chapters 286A, 287A, 289, 293, 294 and 295,
10 including but not limited to investment contracts and agreements, banking services, clearing house
11 services and collateralization agreements, bond documents, certificates of participation and other
12 debt repayment agreements, and any associated contracts, agreements and documents, regardless of
13 whether the obligations that the contracts, agreements or documents establish are general, special
14 or limited, except that the State Treasurer's public contracting for goods and services is subject to
15 ORS chapter 279B;

16 (q) Contracts, agreements or other documents entered into, issued or established in connection
17 with:

18 (A) The issuance of obligations, as defined in ORS 286A.100 and 287A.310, of a public body;

19 (B) The making of program loans and similar extensions or advances of funds, aid or assistance
20 by a public body to a public or private body for the purpose of carrying out, promoting or sustaining
21 activities or programs authorized by law; or

22 (C) The investment of funds by a public body as authorized by law, and other financial trans-
23 actions of a public body that by their character cannot practically be established under the com-
24 petitive contractor selection procedures of ORS 279B.050 to 279B.085;

25 (r) Contracts for employee benefit plans as provided in ORS 243.105 [(1)] (2), 243.125 (4), 243.221,
26 243.275, 243.291, 243.303 and 243.565;

27 (s) Contracts for employee benefit plans as provided in ORS 243.860 to 243.886; or

28 (t) Any other public contracting of a public body specifically exempted from the code by another
29 provision of law.

30 (3) The Public Contracting Code does not apply to the contracting activities of:

31 (a) The Oregon State Lottery Commission;

32 (b) The legislative department;

33 (c) The judicial department;

34 (d) Semi-independent state agencies listed in ORS 182.454, except as provided in ORS 279.835 to
35 279.855 and 279A.250 to 279A.290;

36 (e) Oregon Corrections Enterprises;

37 (f) The Oregon Film and Video Office, except as provided in ORS 279A.100 and 279A.250 to
38 279A.290;

39 (g) The Travel Information Council, except as provided in ORS 279A.250 to 279A.290;

40 (h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

41 (i) The Oregon Innovation Council;

42 (j) The Oregon Utility Notification Center; or

43 (k) Any other public body specifically exempted from the code by another provision of law.

44 (4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to contracts made with
45 qualified nonprofit agencies providing employment opportunities for individuals with disabilities un-

1 der ORS 279.835 to 279.855.

2 **SECTION 11.** ORS 414.653 is amended to read:

3 414.653. (1) The Oregon Health Authority shall encourage coordinated care organizations to use
4 alternative payment methodologies that:

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

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

8 (c) Reward good performance;

9 (d) Limit increases in medical costs; and

10 (e) Use payment structures that create incentives to:

11 (A) Promote prevention;

12 (B) Provide person centered care; and

13 (C) Reward comprehensive care coordination using delivery models such as patient centered
14 primary care homes and behavioral health homes.

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

18 *[(3) A coordinated care organization that participates in a national primary care medical home
19 payment model, conducted by the Center for Medicare and Medicaid Innovation in accordance with 42
20 U.S.C. 1315a, that includes performance-based incentive payments for primary care, shall offer similar
21 alternative payment methodologies to all patient centered primary care homes identified in accordance
22 with ORS 413.259 that serve members of the coordinated care organization.]*

23 *[(4) (3) The authority shall assist and support coordinated care organizations in identifying
24 cost-cutting measures.*

25 *[(5) (4) If a service provided in a health care facility is not covered by Medicare because the
26 service is related to a health care acquired condition, the cost of the service may not be:*

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

29 (b) Reimbursed by a coordinated care organization.

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

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

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

44 (d) This subsection does not prohibit a coordinated care organization and a hospital from mu-
45 tually agreeing to reimbursement other than the reimbursement specified in paragraph (a) of this

1 subsection.

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

4 [(7)] (6) Notwithstanding subsections (1) and (2) of this section, coordinated care organizations
5 must comply with federal requirements for payments to providers of Indian health services, including
6 but not limited to the requirements of 42 U.S.C. 1396j and 42 U.S.C. 1396u-2(a)(2)(C).

7 **SECTION 12.** ORS 743.010, as amended by section 15, chapter 489, Oregon Laws 2017, is
8 amended to read:

9 743.010. (1) In addition to all other powers of the Director of the Department of Consumer and
10 Business Services with respect thereto, the director may issue rules with respect to policy forms and
11 health benefit plan forms described in ORS 742.005 (6)(a) and (b):

12 (a) Establishing minimum benefit standards;

13 (b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in
14 order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the
15 insurer's compliance;

16 (c) Establishing requirements intended to discourage duplication or overlapping of coverage and
17 replacement, without regard to the advantage to policyholders, of existing policies by new policies;
18 [and]

19 (d) Establishing requirements [for] **to encourage** carriers offering health benefit plans to:

20 (A) Spend at least 12 percent of total medical expenditures on payments for primary care; **and**

21 (B) **Reimburse a percentage, as established by the director by rule, in collaboration with**
22 **the Oregon Health Authority, of all primary care costs using alternative payment method-**
23 **ologies;**

24 (e) **Requiring carriers to submit with each rate filing a plan to increase, by at least one**
25 **percent each plan year:**

26 (A) **The percentage of total medical expenditures spent on payments for primary care;**
27 **and**

28 (B) **The percentage of primary care costs that are reimbursed using alternative payment**
29 **methodologies; and**

30 (f) **Requiring carriers to report to the authority, no later than December 1 of each cal-**
31 **endar year, specifying for the next calendar year:**

32 (A) **The percentage of total medical expenditures that the carrier anticipates spending**
33 **on primary care;**

34 (B) **The percentage of spending on primary care that will be made using alternative**
35 **payment methodologies; and**

36 (C) **The types of payment methodologies that will be used to reimburse health care pro-**
37 **viders.**

38 (2) As used in this section:

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

40 (b) **"Behavioral health clinician" means:**

41 (A) **A psychiatrist;**

42 (B) **A psychologist licensed under ORS 675.010 to 675.150;**

43 (C) **A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
44 **chiatric mental health;**

45 (D) **A clinical social worker licensed under ORS 675.530;**

1 (E) A marriage and family therapist or professional counselor licensed under ORS
2 675.715;

3 (F) A clinical social work associate certified under ORS 675.537; or

4 (G) An intern or resident who is working under a board-approved supervisory contract
5 in a clinical mental health field.

6 (c) “Patient centered primary care home” has the meaning given that term in ORS
7 414.025.

8 [(a)] (d) “Primary care” means family medicine, general internal medicine, naturopathic medi-
9 cine, [obstetrics and gynecology,] pediatrics [or general psychiatry] and care provided by primary
10 care integrated behavioral health clinicians or primary care integrated women’s health
11 clinicians.

12 (e) “Primary care integrated behavioral health clinician” means:

13 (A) A care team member, as defined in ORS 414.025 (15)(b); or

14 (B) A behavioral health clinician providing care to individuals and families in a patient
15 centered primary care home to address one or more of the following:

16 (i) Mental illness.

17 (ii) Substance use disorders.

18 (iii) Health behaviors that contribute to chronic illness.

19 (iv) Life stressors and crises.

20 (v) Developmental risks and conditions.

21 (vi) Stress-related physical symptoms.

22 (vii) Preventive care.

23 (viii) Ineffective patterns of health care utilization.

24 (f) “Primary care integrated women’s health clinician” means one of the following
25 clinicians whose practice is focused on women’s health and primary care and who provides
26 a range of the services within a patient centered primary care home:

27 (A) A physician who is an obstetrician or gynecologist;

28 (B) A nurse practitioner;

29 (C) A physician assistant; or

30 (D) Another health professional licensed or certified in this state.

31 [(b)] (g) “Total medical expenditures” means payments to reimburse the cost of physical and
32 mental health care provided to enrollees, excluding [prescription drugs,] vision care and dental care,
33 whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment
34 mechanism.

35 **SECTION 13.** ORS 743.010, as amended by section 15, chapter 489, Oregon Laws 2017, and
36 section 12 of this 2019 Act, is amended to read:

37 743.010. (1) In addition to all other powers of the Director of the Department of Consumer and
38 Business Services with respect thereto, the director may issue rules with respect to policy forms and
39 health benefit plan forms described in ORS 742.005 (6)(a) and (b):

40 (a) Establishing minimum benefit standards;

41 (b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in
42 order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the
43 insurer’s compliance;

44 (c) Establishing requirements intended to discourage duplication or overlapping of coverage and
45 replacement, without regard to the advantage to policyholders, of existing policies by new policies;

- 1 (d) Establishing requirements *[to encourage]* **for** carriers offering health benefit plans to:
- 2 (A) Spend at least 12 percent of total medical expenditures on payments for primary care; and
- 3 (B) Reimburse a percentage, as established by the director by rule, in collaboration with the
- 4 Oregon Health Authority, of all primary care costs using alternative payment methodologies; **and**
- 5 *[(e) Requiring carriers to submit with each rate filing a plan to increase, by at least one percent*
- 6 *each plan year:]*
- 7 *[(A) The percentage of total medical expenditures spent on payments for primary care; and]*
- 8 *[(B) The percentage of primary care costs that are reimbursed using alternative payment method-*
- 9 *ologies; and]*
- 10 *[(f)]* (e) Requiring carriers to report to the authority, no later than December 1 of each calendar
- 11 year, specifying for the next calendar year:
- 12 (A) The percentage of total medical expenditures that the carrier anticipates spending on pri-
- 13 mary care;
- 14 (B) The percentage of spending on primary care that will be made using alternative payment
- 15 methodologies; and
- 16 (C) The types of payment methodologies that will be used to reimburse health care providers.
- 17 (2) As used in this section:
- 18 (a) “Alternative payment methodology” has the meaning given that term in ORS 414.025.
- 19 (b) “Behavioral health clinician” means:
- 20 (A) A psychiatrist;
- 21 (B) A psychologist licensed under ORS 675.010 to 675.150;
- 22 (C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psychiatric
- 23 mental health;
- 24 (D) A clinical social worker licensed under ORS 675.530;
- 25 (E) A marriage and family therapist or professional counselor licensed under ORS 675.715;
- 26 (F) A clinical social work associate certified under ORS 675.537; or
- 27 (G) An intern or resident who is working under a board-approved supervisory contract in a
- 28 clinical mental health field.
- 29 (c) “Patient centered primary care home” has the meaning given that term in ORS 414.025.
- 30 (d) “Primary care” means family medicine, general internal medicine, naturopathic medicine,
- 31 pediatrics and care provided by primary care integrated behavioral health clinicians or primary care
- 32 integrated women’s health clinicians.
- 33 (e) “Primary care integrated behavioral health clinician” means:
- 34 (A) A care team member, as defined in ORS 414.025 (15)(b); or
- 35 (B) A behavioral health clinician providing care to individuals and families in a patient centered
- 36 primary care home to address one or more of the following:
- 37 (i) Mental illness.
- 38 (ii) Substance use disorders.
- 39 (iii) Health behaviors that contribute to chronic illness.
- 40 (iv) Life stressors and crises.
- 41 (v) Developmental risks and conditions.
- 42 (vi) Stress-related physical symptoms.
- 43 (vii) Preventive care.
- 44 (viii) Ineffective patterns of health care utilization.
- 45 (f) “Primary care integrated women’s health clinician” means one of the following clinicians

1 whose practice is focused on women’s health and primary care and who provides a range of the
2 services within a patient centered primary care home:

- 3 (A) A physician who is an obstetrician or gynecologist;
- 4 (B) A nurse practitioner;
- 5 (C) A physician assistant; or
- 6 (D) Another health professional licensed or certified in this state.

7 (g) “Total medical expenditures” means payments to reimburse the cost of physical and mental
8 health care provided to enrollees, excluding vision care and dental care, whether paid on a fee-for-
9 service basis or as part of a capitated rate or other type of payment mechanism.

10 **SECTION 14.** Section 1, chapter 575, Oregon Laws 2015, as amended by section 12, chapter 489,
11 Oregon Laws 2017, is amended to read:

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

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

14 (b) “Prominent carrier” means:

15 (A) A carrier with annual premium income at a threshold, of no less than \$50 million, estab-
16 lished by the Department of Consumer and Business Services by rule.

17 (B) The Public Employees’ Benefit Board.

18 (C) The Oregon Educators Benefit Board.

19 (2) All prominent carriers shall, and carriers other than prominent carriers may, report to the
20 Department of Consumer and Business Services, no later than October 1 of each year, the proportion
21 of the carrier’s total medical [*expenses*] **expenditures** that are allocated to primary care.

22 (3) The department shall share with the Oregon Health Authority the information reported so
23 that the authority may prepare the evaluation and [*report*] **reports** described in [*section 2*] **sections**
24 **2 and 3**, chapter 575, Oregon Laws 2015.

25 (4) The department, in collaboration with the authority, shall adopt rules prescribing the pri-
26 mary care services for which costs must be reported under subsection (2) of this section.

27 **SECTION 15.** Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chapter 384,
28 Oregon Laws 2017, and section 13, chapter 489, Oregon Laws 2017, is amended to read:

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

30 (a) **“Behavioral health clinician” means:**

31 (A) **A psychiatrist;**

32 (B) **A psychologist licensed under ORS 675.010 to 675.150;**

33 (C) **A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psy-**
34 **chiatric mental health;**

35 (D) **A clinical social worker licensed under ORS 675.530;**

36 (E) **A marriage and family therapist or professional counselor licensed under ORS**
37 **675.715;**

38 (F) **A clinical social work associate certified under ORS 675.537; or**

39 (G) **An intern or resident who is working under a board-approved supervisory contract**
40 **in a clinical mental health field.**

41 [(a)] (b) “Carrier” means an insurer that offers a health benefit plan, as defined in ORS
42 743B.005.

43 [(b)] (c) “Coordinated care organization” has the meaning given that term in ORS 414.025.

44 (d) **“Patient centered primary care home” has the meaning given that term in ORS**
45 **414.025.**

1 [(c)] (e) “Primary care” means family medicine, general internal medicine, naturopathic medi-
2 cine, [obstetrics and gynecology,] pediatrics [or general psychiatry] **and care provided by primary**
3 **care integrated behavioral health clinicians or primary care integrated women’s health**
4 **clinicians.**

5 (f) “Primary care integrated behavioral health clinician” means:

6 (A) A care team member as defined in ORS 414.025 (15)(b); or

7 (B) A behavioral health clinician providing care to individuals and families in a patient
8 centered primary care home to address one or more of the following:

9 (i) Mental illness.

10 (ii) Substance use disorders.

11 (iii) Health behaviors that contribute to chronic illness.

12 (iv) Life stressors and crises.

13 (v) Developmental risks and conditions.

14 (vi) Stress-related physical symptoms.

15 (vii) Preventive care.

16 (viii) Ineffective patterns of health care utilization.

17 (g) “Primary care integrated women’s health clinician” means one of the following
18 clinicians whose practice is focused on women’s health and primary care and who provides
19 a range of the services within a patient centered primary care home:

20 (A) A physician who is an obstetrician or gynecologist;

21 (B) A nurse practitioner;

22 (C) A physician assistant; or

23 (D) Another health professional licensed or certified in this state.

24 [(d)] (h) “Primary care provider” includes:

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

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

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

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

32 (i) Increase the investment in primary care;

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

34 (iii) Continue to improve reimbursement methods, including by investing in the social determi-
35 nants of health;

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

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

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

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

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

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

44 (3) The authority shall invite representatives from all of the following to participate in the pri-
45 mary care payment reform collaborative:

- 1 (a) Primary care providers;
- 2 (b) Health care consumers;
- 3 (c) Experts in primary care contracting and reimbursement;
- 4 (d) Independent practice associations;
- 5 (e) Behavioral health treatment providers;
- 6 (f) Third party administrators;
- 7 (g) Employers that offer self-insured health benefit plans;
- 8 (h) The Department of Consumer and Business Services;
- 9 (i) Carriers;
- 10 (j) A statewide organization for mental health professionals who provide primary care;
- 11 (k) A statewide organization representing federally qualified health centers;
- 12 (L) A statewide organization representing hospitals and health systems;
- 13 (m) A statewide professional association for family physicians;
- 14 (n) A statewide professional association for physicians;
- 15 (o) A statewide professional association for nurses; and
- 16 (p) The Centers for Medicare and Medicaid Services.

17 (4) The primary care payment reform collaborative shall annually report to the Oregon Health
18 Policy Board and to the Legislative Assembly on the achievement of the primary care [*spending*
19 *targets*] **financial requirements** in ORS 414.625 and 743.010 and the implementation of the Primary
20 Care Transformation Initiative.

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

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

27 **SECTION 16.** Section 3, chapter 575, Oregon Laws 2015, as amended by section 7, chapter 26,
28 Oregon Laws 2016, is amended to read:

29 **Sec. 3.** No later than February 1 of each year, the Oregon Health Authority and the Department
30 of Consumer and Business Services shall report to the Legislative Assembly, in the manner provided
31 in ORS 192.245:

32 (1) The percentage of the medical expenses of carriers, coordinated care organizations, the
33 Public Employees' Benefit Board and the Oregon Educators Benefit Board that is allocated to pri-
34 mary care; [*and*]

35 (2) How carriers, coordinated care organizations, the Public Employees' Benefit Board and the
36 Oregon Educators Benefit Board pay for primary care; **and**

37 **(3) As reported to the authority and the Department of Consumer and Business Services**
38 **under ORS 243.135 and 243.866 and section 2 of this 2019 Act:**

39 **(a) The percentage of total medical expenditures that carriers, coordinated care organ-**
40 **izations, the Oregon Educators Benefit Board and the Public Employees' Benefit Board an-**
41 **anticipate spending on primary care for the calendar year;**

42 **(b) The percentage of spending on primary care by carriers, coordinated care organiza-**
43 **tions, the Oregon Educators Benefit Board and the Public Employees' Benefit Board that**
44 **will be in the form of alternative payment methodologies, as defined in ORS 414.025, in the**
45 **calendar year; and**

1 **(c) The types of alternative payment methodologies that carriers, coordinated care or-**
2 **ganizations, the Oregon Educators Benefit Board and the Public Employees' Benefit Board**
3 **will use in the calendar year.**

4 **SECTION 17.** Section 2 of this 2019 Act is amended to read:

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

6 (a) "Behavioral health clinician" means:

7 (A) A psychiatrist;

8 (B) A psychologist licensed under ORS 675.010 to 675.150;

9 (C) A nurse practitioner, licensed under ORS 678.375 to 678.390, with a specialty in psychiatric
10 mental health;

11 (D) A clinical social worker licensed under ORS 675.530;

12 (E) A marriage and family therapist or professional counselor licensed under ORS 675.715;

13 (F) A clinical social work associate certified under ORS 675.537; or

14 (G) An intern or resident who is working under a board-approved supervisory contract in a
15 clinical mental health field.

16 (b) "Primary care" means family medicine, general internal medicine, naturopathic medicine,
17 pediatrics and care provided by primary care integrated behavioral health clinicians or primary care
18 integrated women's health clinicians.

19 (c) "Primary care integrated behavioral health clinician" means:

20 (A) A care team member as defined in ORs 414.025 (15)(b); or

21 (B) A behavioral health clinician providing care to individuals and families in a patient centered
22 primary care home to address one or more of the following:

23 (i) Mental illness.

24 (ii) Substance use disorders.

25 (iii) Health behaviors that contribute to chronic illness.

26 (iv) Life stressors and crises.

27 (v) Developmental risks and conditions.

28 (vi) Stress-related physical symptoms.

29 (vii) Preventive care.

30 (viii) Ineffective patterns of health care utilization.

31 (d) "Primary care integrated women's health clinician" means one of the following clinicians
32 whose practice is focused on women's health and primary care and who provides a range of the
33 services within a patient centered primary care home:

34 (A) A physician who is an obstetrician or gynecologist;

35 (B) A nurse practitioner;

36 (C) A physician assistant; or

37 (D) Another health professional licensed or certified in this state.

38 (e) "Total medical expenditures" means total expenditures for physical and mental health care
39 provided to members of a coordinated care organization, excluding expenditures for vision care and
40 dental care.

41 (2) *[No later than January 1, 2023,]* A coordinated care organization must spend at least 12
42 percent of the coordinated care organization's total medical expenditures on primary care.

43 (3) *[No later than January 1, 2020,]* A coordinated care organization must reimburse a percent-
44 age, as established by the Oregon Health Authority by rule, of all primary care costs using alter-
45 native payment methodologies.

1 (4) After the Oregon Health Authority has established a global budget for a coordinated care
2 organization for a calendar year, the coordinated care organization shall report to the authority,
3 at the time and in the manner prescribed by the authority by rule:

4 (a) The percentage of the global budget that the coordinated care organization anticipates
5 spending on primary care;

6 (b) The percentage of the spending on primary care that will be in the form of alternative pay-
7 ment methodologies; and

8 (c) The types of alternative payment methodologies that the coordinated care organization will
9 use during the calendar year.

10 **SECTION 18.** ORS 414.625, as amended by section 14, chapter 489, Oregon Laws 2017, and
11 section 4, chapter 49, Oregon Laws 2018, is amended to read:

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

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

24 (b) Meet the following minimum financial requirements:

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

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

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

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

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

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

43 (f) Engage community members and health care providers in improving the health of the com-
44 munity and addressing regional, cultural, socioeconomic and racial disparities in health care that
45 exist among the coordinated care organization's members and in the coordinated care organization's

1 community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (E) Include providers of specialty care.

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

1 quality standards.

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

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

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

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

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

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

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

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

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

18 (i) A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS
19 678.375, whose area of practice is primary care; and

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

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

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

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

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

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

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

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

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

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

38 **SECTION 19.** Section 3, chapter 489, Oregon Laws 2017, is amended to read:

39 **Sec. 3.** (1) As used in this section[,]:

40 (a) "Primary care" has the meaning given that term in section [2, chapter 575, Oregon Laws
41 2015] **2 of this 2019 Act.**

42 (b) "**Total medical expenditures**" has the meaning given that term in section **2 of this 2019**
43 **Act.**

44 (2) A coordinated care organization that [*spends on primary care less than 12 percent of its total*
45 *expenditures on physical and mental health care, as required by ORS 414.625 (1)(c),*] **fails to meet**

1 **the financial requirements in section 2 (2) and (3) of this 2019 Act for expenditures related**
2 **to primary care** shall submit to the Oregon Health Authority a plan to increase, **by at least one**
3 **percent each year:**

4 (a) **The coordinated care organization's** spending on primary care as a percentage of its total
5 **medical expenditures** [*by at least one percent each year*] **on primary care; and**

6 (b) **The percentage of all primary care costs reimbursed by the coordinated care organ-**
7 **ization using alternative payment methodologies.**

8 **SECTION 20.** Section 20, chapter 489, Oregon Laws 2017, is amended to read:

9 **Sec. 20. (1)** [*Section 3 of this 2017 Act and*] The amendments to ORS [*414.625,*] 243.135[,] **and**
10 243.866 [*and 743.010*] by sections [*14 to*] **16 and 17,** [*of this 2017 Act*] **chapter 489, Oregon Laws**
11 **2017,** become operative on January 1, 2023.

12 (2) **The amendments to ORS 743.010 by section 13 of this 2019 Act become operative on**
13 **the date set forth in subsection (1) of this section.**

14 **SECTION 21.** Section 5, chapter 575, Oregon Laws 2015, as amended by section 8, chapter 26,
15 Oregon Laws 2016, and section 19, chapter 489, Oregon Laws 2017, is amended to read:

16 **Sec. 5. (1)(a) Section 1, chapter 575, Oregon Laws 2015, as amended by section 12, chapter**
17 **489, Oregon Laws 2017, and section 14 of this 2019 Act is repealed on December 31, 2027.**

18 (b) **Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chapter 384,**
19 **Oregon Laws 2017, section 13, chapter 489, Oregon Laws 2017, and section 15 of this 2019 Act**
20 **is repealed on December 31, 2027.**

21 (c) **Section 3, chapter 575, Oregon Laws 2015, as amended by section 7, chapter 26, Oregon**
22 **Laws 2016, and section 16 of this 2019 Act is repealed on December 31, 2027.**

23 [(1)] (d) [*Sections 1 to 4*] **Section 4,** chapter 575, Oregon Laws 2015, [*are*] is repealed on De-
24 cember 31, 2027.

25 (2) **Section 3, chapter 489, Oregon Laws 2017, as amended by section 19 of this 2019 Act,**
26 [*of this 2017 Act*] is repealed on December 31, 2027.

27 **SECTION 22.** ORS 743B.458 is repealed.

28 **SECTION 23.** The amendments to section 2 of this 2019 Act by section 17 of this 2019 Act
29 **become operative on January 1, 2023.**

30