

HOUSE AMENDMENTS TO HOUSE BILL 3353

By COMMITTEE ON HEALTH CARE

April 19

1 On page 1 of the printed bill, after line 2, insert:

2 “Whereas achieving health equity requires the ongoing collaboration of all regions and sections
3 of this state, including tribal governments, to address the equitable distribution or redistribution of
4 resources and power and to recognize, reconcile and rectify historical and contemporary injustices;
5 now, therefore,”.

6 Delete lines 4 through 28 and delete page 2.

7 On page 3, delete lines 1 through 25 and insert:

8 **“SECTION 1. (1) As used in this section, ‘health equity’ means all people can reach their
9 full health potential and well-being and are not disadvantaged by their race, ethnicity, lan-
10 guage, disability, gender, gender identity, sexual orientation, social class, intersections
11 among these communities or identities or other socially determined circumstances.**

12 **“(2) The Oregon Health Authority shall seek approval from the Centers for Medicare and
13 Medicaid Services to amend the Medicaid demonstration project under section 1115 of the
14 Social Security Act (42 U.S.C. 1315) to:**

15 **“(a) Allow a coordinated care organization to spend up to three percent of its global
16 budget on investments:**

17 **“(A)(i) In programs or services that improve health equity by addressing the preventable
18 differences in the burden of disease, injury, violence or opportunities to achieve optimal
19 health that are experienced by socially disadvantaged populations;**

20 **“(ii) In community-based programs addressing the social determinants of health;**

21 **“(iii) In efforts to diversify care locations; or**

22 **“(iv) In programs or services that improve the overall health of the community; or**

23 **“(B) That enhance payments to:**

24 **“(i) Providers who address the need for culturally and linguistically appropriate services
25 in their communities;**

26 **“(ii) Providers who can demonstrate that increased funding will improve health services
27 provided to the community as a whole; or**

28 **“(iii) Support staff based in the community that aid all underserved populations, including
29 but not limited to peer-to-peer support staff with cultural backgrounds, health system
30 navigators in nonmedical settings and public guardians.**

31 **“(b) Require a coordinated care organization to spend at least 30 percent of the funds
32 described in paragraph (a) of this subsection on programs or efforts to achieve health equity
33 for priority populations that are underserved in the communities served by the coordinated
34 care organization.**

35 **“(c) Require a coordinated care organization to spend at least 20 percent of the funds**

1 described in paragraph (a) of this subsection on efforts to:

2 “(A) Improve the behavioral health of members;

3 “(B) Improve the behavioral health care delivery system in the community served by the
4 coordinated care organization;

5 “(C) Create a culturally and linguistically competent health care workforce; or

6 “(D) Improve the behavioral health of the community as a whole.

7 “(3) Expenditures described in subsection (2) of this section are in addition to the
8 expenditures required by ORS 414.572 (1)(b)(C) and must:

9 “(a) Be part of a plan developed in collaboration with or directed by members of organ-
10 izations or organizations that serve local priority populations that are underserved in com-
11 munities served by the coordinated care organization, including but not limited to regional
12 health equity coalitions, and be approved by the coordinated care organization’s community
13 advisory council;

14 “(b) Demonstrate, through practice-based or community-based evidence, improved health
15 outcomes for individual members of the coordinated care organization or the overall com-
16 munity served by the coordinated care organization;

17 “(c) Be expended from a coordinated care organization’s global budget with the least
18 amount of state funding; and

19 “(d) Be counted as medical expenses by the authority for purposes of a coordinated care
20 organization’s required medical loss ratio and be taken into account by the authority when
21 calculating a coordinated care organization’s global budget for the next calendar year.

22 “(4) Expenditures by a coordinated care organization in working with tribal governments
23 to achieve health equity may qualify as expenditures under subsection (2) of this section.

24 “(5) The authority shall convene an oversight committee in consultation with the office
25 within the authority that is charged with ensuring equity and inclusion. The oversight com-
26 mittee shall be composed of members who represent the regional and demographic diversity
27 of this state based on statistical evidence compiled by the authority about medical assistance
28 recipients. The oversight committee shall:

29 “(a) Evaluate the impact of expenditures described in subsection (2) of this section on
30 promoting health equity and improving the social determinants of health in the community;

31 “(b) Recommend best practices and criteria for investments described in subsection (2)
32 of this section; and

33 “(c) Resolve any disputes between the authority and a coordinated care organization over
34 what qualifies as an expenditure under subsection (2) of this section.

35 “(6) The authority shall:

36 “(a) Make publicly available the outcomes described in subsection (3)(b) of this section;
37 and

38 “(b) Report expenditures under subsection (2) of this section to the Centers for Medicare
39 and Medicaid Services.

40 “**SECTION 2.** Section 1 of this 2021 Act is amended to read:

41 “**Sec. 1.** (1) As used in this section, ‘health equity’ means when all people can reach their full
42 health potential and well-being and are not disadvantaged by their race, ethnicity, language, disa-
43 bility, gender, gender identity, sexual orientation, social class, intersections among these communi-
44 ties or identities or other socially determined circumstances.

45 “(2) The Oregon Health Authority shall *[seek approval from the Centers for Medicare and*

1 *Medicaid Services to amend the Medicaid demonstration project under section 1115 of the Social Se-*
2 *curity Act (42 U.S.C. 1315) to):*

3 “(a) Allow a coordinated care organization to spend up to three percent of its global budget on
4 investments:

5 “(A)(i) In programs or services that improve health equity by addressing the preventable differ-
6 ences in the burden of disease, injury, violence or opportunities to achieve optimal health that are
7 experienced by socially disadvantaged populations;

8 “(ii) In community-based programs addressing the social determinants of health;

9 “(iii) In efforts to diversify care locations; or

10 “(iv) In programs or services that improve the overall health of the community; or

11 “(B) That enhance payments to:

12 “(i) Providers who address the need for culturally and linguistically appropriate services in their
13 communities;

14 “(ii) Providers who can demonstrate that increased funding will improve health services pro-
15 vided to the community as a whole; or

16 “(iii) Support staff based in the community that aid all underserved populations, including but
17 not limited to peer-to-peer support staff with cultural backgrounds, health system navigators in
18 nonmedical settings and public guardians.

19 “(b) Require a coordinated care organization to spend at least 30 percent of the funds described
20 in paragraph (a) of this subsection on programs or efforts to achieve health equity for priority pop-
21 ulations that are underserved in the communities served by the coordinated care organization.

22 “(c) Require a coordinated care organization to spend at least 20 percent of the funds described
23 in paragraph (a) of this subsection on efforts to:

24 “(A) Improve the behavioral health of members;

25 “(B) Improve the behavioral health care delivery system in the communities served by the co-
26 ordinated care organization;

27 “(C) Create a culturally and linguistically competent health care workforce; or

28 “(D) Improve the behavioral health of the community as a whole.

29 “(3) Expenditures described in subsection (2) of this section are in addition to the expenditures
30 required by ORS 414.572 (1)(b)(C) and must:

31 “(a) Be part of a plan developed in collaboration with or directed by members of organizations
32 or organizations that serve local priority populations that are underserved in communities served
33 by the coordinated care organization, including but not limited to regional health equity coalitions,
34 and be approved by the coordinated care organization’s community advisory council;

35 “(b) Demonstrate, through practice-based [*or community-based*] evidence, improved health out-
36 comes for individual members of the coordinated care organization or the overall community served
37 by the coordinated care organization;

38 “(c) Be expended from a coordinated care organization’s global budget with the least amount
39 of state funding; and

40 “(d) Be counted as medical expenses by the authority for purposes of a coordinated care
41 organization’s required medical loss ratio and be taken into account by the authority when calcu-
42 lating a coordinated care organization’s global budget for the next calendar year.

43 “(4) Expenditures by a coordinated care organization in working with tribal governments to
44 achieve health equity may qualify as expenditures under subsection (2) of this section.

45 “(5) The authority shall convene an oversight committee in consultation with the office within

1 the authority that is charged with ensuring equity and inclusion. The oversight committee shall be
2 composed of members who represent the regional and demographic diversity of this state based on
3 statistical evidence compiled by the authority about medical assistance recipients. The oversight
4 committee shall:

5 “(a) Evaluate the impact of expenditures described in subsection (2) of this section on promoting
6 health equity and improving the social determinants of health in the community;

7 “(b) Recommend best practices and criteria for investments described in subsection (2) of this
8 section; and

9 “(c) Resolve any disputes between the authority and a coordinated care organization over what
10 qualifies as an expenditure under subsection (2) of this section.

11 “(6) The authority shall:

12 “(a) Make publicly available the outcomes described in subsection (3)(b) of this section; and

13 “(b) Report expenditures under subsection (2) of this section to the Centers for Medicare and
14 Medicaid Services.”.

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