

House Bill 3444

Sponsored by Representatives DEXTER, BOWMAN

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 **as introduced**.

Establishes Office of Health Care Affordability and transfers to office functions of Oregon Health Authority related to containment of health care costs.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

1
2 Relating to health care; creating new provisions; amending ORS 413.017, 413.032, 413.037, 413.101,
3 413.181, 415.231, 413.248, 413.259, 413.260, 414.025, 414.591, 414.619, 414.655, 415.013, 415.019,
4 415.103, 415.500, 415.501, 415.505, 415.510, 415.512, 415.900, 433.301, 442.315, 442.325, 442.342,
5 442.362, 442.370, 442.373, 442.386, 442.392, 442.394, 442.396, 442.420, 442.425, 442.430, 442.460,
6 442.463, 442.991, 442.993, 442.994, 646A.694 and 743A.078 and sections 2 to 4, chapter 575, Oregon
7 Laws 2015, and section 6a, chapter 615, Oregon Laws 2021; and prescribing an effective date.

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

OFFICE OF HEALTH CARE AFFORDABILITY

(Establishment)

9
10
11
12
13 **SECTION 1. (1) The Office of Health Care Affordability is established.**

14 **(2) The Office of Health Care Affordability is under the supervision and control of a di-**
15 **rector, who is responsible for the performance of the duties, functions and powers of the**
16 **office.**

17 **(3) The Governor shall appoint the Director of the Office of Health Care Affordability,**
18 **who holds office at the pleasure of the Governor.**

19 **(4) The director shall be paid a salary as provided by law or, if not so provided, as pre-**
20 **scribed by the Governor.**

21 **(5) Subject to the approval of the Governor, the director may organize and reorganize the**
22 **administrative structure of the office as the director considers appropriate to properly con-**
23 **duct the work of the office.**

24 **(6) The director may divide the functions of the office into administrative divisions.**
25 **Subject to the approval of the Governor, the director may appoint an individual to administer**
26 **each division. The administrator of each division serves at the pleasure of the director and**
27 **is not subject to the provisions of ORS chapter 240. Each individual appointed under this**
28 **subsection must be well qualified by technical training and experience in the functions to be**
29 **performed by the individual.**

30 **(7) The appointment of the Director of the Office of Health Care Affordability is subject**
31 **to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.**

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 (8) The director shall, by written order filed with the Secretary of State, appoint a deputy
 2 director. The deputy director serves at the pleasure of the director, has authority to act for
 3 the director in the absence of the director and is subject to the control of the director at
 4 all times.

5 (9) Subject to any applicable provisions of ORS chapter 240, the director shall appoint all
 6 subordinate officers and employees of the office, prescribe their duties and fix their com-
 7 pensation.

8 (10) In accordance with the provisions of ORS chapter 183, the office may adopt rules for
 9 the administration of the laws that the office is charged with administering.

10 (11) The Director of the Office of Health Care Affordability, the deputy director and au-
 11 thorized representatives of the director may administer oaths, take depositions and issue
 12 subpoenas to compel the attendance of witnesses and the production of documents or other
 13 written information necessary to carry out the provisions of sections 1 to 3, 16, 19 and 39
 14 of this 2023 Act and the amendments to ORS 413.017, 413.032, 413.037, 413.101, 413.181, 413.231,
 15 413.248, 413.259, 413.260, 414.025, 414.591, 414.619, 414.655, 415.013, 415.019, 415.103, 415.500,
 16 415.501, 415.505, 415.510, 415.512, 415.900, 433.301, 442.315, 442.325, 442.342, 442.362, 442.370,
 17 442.373, 442.386, 442.392, 442.394, 442.396, 442.420, 442.425, 442.430, 442.460, 442.463, 442.991,
 18 442.993, 442.994, 646A.694 and 743A.078 and sections 2 to 4, chapter 575, Oregon Laws 2015, and
 19 section 6a, chapter 615, Oregon Laws 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this
 20 2023 Act. If any person fails to comply with a subpoena issued under this section or refuses
 21 to testify on matters on which the person lawfully may be interrogated, the director, deputy
 22 director or authorized representative may follow the procedure set out in ORS 183.440 to
 23 compel obedience.

24
 25 (Transfer of Duties and Functions from
 26 Oregon Health Authority)
 27

28 **SECTION 2.** (1) On the operative date of this section, the duties, functions and powers
 29 of the Oregon Health Authority and the Oregon Health Policy Board as provided in amend-
 30 ments to ORS 413.017, 413.032, 413.037, 413.101, 413.181, 413.231, 413.248, 413.259, 413.260,
 31 414.025, 414.591, 414.619, 414.655, 415.013, 415.019, 415.103, 415.500, 415.501, 415.505, 415.510,
 32 415.512, 415.900, 433.301, 442.315, 442.325, 442.342, 442.362, 442.370, 442.373, 442.386, 442.392,
 33 442.394, 442.396, 442.420, 442.425, 442.430, 442.460, 442.463, 442.991, 442.993, 442.994, 646A.694 and
 34 743A.078 and sections 2 to 4, chapter 575, Oregon Laws 2015, and section 6a, chapter 615,
 35 Oregon Laws 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this 2023 Act are trans-
 36 ferred to and vested in the Office of Health Care Affordability established in section 1 of this
 37 2023 Act.

38 (2) The Director of the Oregon Health Authority shall:

39 (a) Deliver to the office all records and property within the jurisdiction of the director
 40 that relate to the duties, functions and powers transferred by this section; and

41 (b) Transfer to the office those employees engaged primarily in the exercise of the duties,
 42 functions and powers transferred by this section.

43 (3) The Director of the Office of Health Care Affordability shall take possession of the
 44 records and property, and shall take charge of the employees and employ them in the exer-
 45 cise of the duties, functions and powers transferred by this section, without reduction of

1 compensation but subject to change or termination of employment or compensation as pro-
2 vided by law.

3 (4) The Governor shall resolve any dispute between the authority and the office relating
4 to transfers of records, property and employees under this section, and the Governor's de-
5 cision is final.

6 (5) The unexpended balances of amounts authorized to be expended by the authority for
7 the biennium beginning July 1, 2023, from revenues dedicated, continuously appropriated,
8 appropriated or otherwise made available for the purpose of administering and enforcing the
9 duties, functions and powers transferred by this section are transferred to and are available
10 for expenditure by the office for the biennium beginning July 1, 2023, for the purpose of ad-
11 ministering and enforcing the duties, functions and powers transferred by this section.

12 (6) The expenditure classifications, if any, established by Acts authorizing or limiting
13 expenditures by the authority remain applicable to expenditures by the office under this
14 section.

15 (7) Nothing in sections 1 to 4, 16, 19 and 39 of this 2023 Act, the amendments to ORS
16 413.017, 413.032, 413.037, 413.101, 413.181, 413.231, 413.248, 413.259, 413.260, 414.025, 414.591,
17 414.619, 414.655, 415.013, 415.019, 415.103, 415.500, 415.501, 415.505, 415.510, 415.512, 415.900,
18 433.301, 442.315, 442.325, 442.342, 442.362, 442.370, 442.373, 442.386, 442.392, 442.394, 442.396,
19 442.420, 442.425, 442.430, 442.460, 442.463, 442.991, 442.993, 442.994, 646A.694 and 743A.078 and
20 sections 2 to 4, chapter 575, Oregon Laws 2015, and section 6a, chapter 615, Oregon Laws
21 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this 2023 Act relieves a person of a li-
22 ability, duty or obligation accruing under or with respect to the duties, functions and powers
23 transferred by this section. The office may undertake the collection or enforcement of any
24 such liability, duty or obligation.

25 (8) The rights and obligations of the authority legally incurred under contracts, leases
26 and business transactions executed, entered into or begun before the operative date of this
27 section are transferred to the office. For the purpose of succession to these rights and obli-
28 gations, the office is a continuation of the authority and not a new agency.

29 (9) Notwithstanding the transfer of duties, functions and powers by this section, the rules
30 of the authority in effect on the operative date of this section continue in effect until su-
31 perseded or repealed by rules of the office. References in rules of the authority to the au-
32 thority or an officer or employee of the authority are considered to be references to the
33 office or an officer or employee of the office.

34 (10) The Director of the Office of Health Care Affordability may be appointed before the
35 operative date of this section and may take any action before that date that is necessary to
36 enable the director to exercise, on and after the operative date of this section, the duties,
37 functions and powers of the director pursuant to sections 1 to 3, 16, 19 and 39 of this 2023
38 Act and the amendments to ORS 413.017, 413.032, 413.037, 413.101, 413.181, 413.231, 413.248,
39 413.259, 413.260, 414.025, 414.591, 414.619, 414.655, 415.013, 415.019, 415.103, 415.500, 415.501,
40 415.505, 415.510, 415.512, 415.900, 433.301, 442.315, 442.325, 442.342, 442.362, 442.370, 442.373,
41 442.386, 442.392, 442.394, 442.396, 442.420, 442.425, 442.430, 442.460, 442.463, 442.991, 442.993,
42 442.994, 646A.694 and 743A.078 and sections 2 to 4, chapter 575, Oregon Laws 2015, and section
43 6a, chapter 615, Oregon Laws 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this 2023
44 Act.

45

(Establishment of Health Care Affordability Fund)

SECTION 3. (1) The Health Care Affordability Fund is created in the State Treasury, separate and distinct from the General Fund, consisting of moneys appropriated to the Office of Health Care Affordability by the Legislative Assembly and moneys received under ORS 415.512, 442.315, 442.420 and 442.993 and any other public or private sources.

(2) Moneys in the Health Care Affordability Fund may be used by the office for carrying out the duties, functions and powers of the office as provided by law.

**DUTIES AND FUNCTIONS TRANSFERRED TO THE
OFFICE OF HEALTH CARE AFFORDABILITY
(Establishment of Health Care Quality Metrics)**

SECTION 4. ORS 413.017 is amended to read:

413.017. (1) The [*Oregon Health Policy Board*] **Office of Health Care Affordability** shall establish the committees described in subsections (2) to (5) of this section.

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

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

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

(b) The Public Health Benefit Purchasers Committee shall:

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

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

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

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

(3)(a) The Health Care Workforce Committee shall include individuals who have the collective

1 expertise, knowledge and experience in a broad range of health professions, health care education
2 and health care workforce development initiatives.

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

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

9 (4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed
10 by the [*Oregon Health Policy Board*] **office**:

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

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

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

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

15 (E) Two health care providers;

16 (F) One individual representing hospitals;

17 (G) One individual representing insurers, large employers or multiple employer welfare ar-
18 rangements;

19 (H) Two individuals representing health care consumers;

20 (I) Two individuals representing coordinated care organizations;

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

22 (K) One individual with expertise in health care quality measures; and

23 (L) One individual with expertise in mental health and addiction services.

24 (b) The committee shall work collaboratively with the **office, the** Oregon Educators Benefit
25 Board, the Public Employees' Benefit Board, the authority and the department to adopt health out-
26 come and quality measures that are focused on specific goals and provide value to the state, em-
27 ployers, insurers, health care providers and consumers. The committee shall be the single body to
28 align health outcome and quality measures used in this state with the requirements of health care
29 data reporting to ensure that the measures and requirements are coordinated, evidence-based and
30 focused on a long term statewide vision.

31 (c) The committee shall use a public process that includes an opportunity for public comment
32 to identify health outcome and quality measures that may be applied to services provided by coord-
33 inated care organizations or paid for by health benefit plans sold through the health insurance
34 exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board.
35 The **office, the** authority, the department, the Oregon Educators Benefit Board and the Public
36 Employees' Benefit Board are not required to adopt all of the health outcome and quality measures
37 identified by the committee but may not adopt any health outcome and quality measures that are
38 different from the measures identified by the committee. The measures must take into account the
39 recommendations of the metrics and scoring subcommittee created in ORS 414.638 and the differ-
40 ences in the populations served by coordinated care organizations and by commercial insurers.

41 (d) In identifying health outcome and quality measures, the committee shall prioritize measures
42 that:

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

1 (B) Given the context in which each measure is applied, are not prone to random variations
2 based on the size of the denominator;

3 (C) Utilize existing data systems, to the extent practicable, for reporting the measures to mini-
4 mize redundant reporting and undue burden on the state, health benefit plans and health care pro-
5 viders;

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

7 (E) Use a common format in the collection of the data and facilitate the public reporting of the
8 data; and

9 (F) Can be reported in a timely manner and without significant delay so that the most current
10 and actionable data is available.

11 (e) The committee shall evaluate on a regular and ongoing basis the health outcome and quality
12 measures adopted under this section.

13 (f) The committee may convene subcommittees to focus on gaining expertise in particular areas
14 such as data collection, health care research and mental health and substance use disorders in order
15 to aid the committee in the development of health outcome and quality measures. A subcommittee
16 may include stakeholders and staff from the **office, the** authority, the Department of Human Ser-
17 vices, the Department of Consumer and Business Services, the Early Learning Council or any other
18 agency staff with the appropriate expertise in the issues addressed by the subcommittee.

19 (g) This subsection does not prevent the **office, the** authority, the Department of Consumer and
20 Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon Educa-
21 tors Benefit Board from establishing programs that provide financial incentives to providers for
22 meeting specific health outcome and quality measures adopted by the committee.

23 (5)(a) The Behavioral Health Committee shall include the following members appointed by the
24 Director of the [*Oregon Health Authority*] **Office of Health Care Affordability**:

25 (A) The chairperson of the Health Plan Quality Metrics Committee;

26 (B) The chairperson of the committee appointed by the [*board*] **office** to address health equity,
27 if any;

28 (C) A behavioral health director for a coordinated care organization;

29 (D) A representative of a community mental health program;

30 (E) An individual with expertise in data analysis;

31 (F) A member of the Consumer Advisory Council, established under ORS 430.073, that represents
32 adults with mental illness;

33 (G) A representative of the System of Care Advisory Council established in ORS 418.978;

34 (H) A member of the Oversight and Accountability Council, described in ORS 430.389, who re-
35 presents adults with addictions or co-occurring conditions;

36 (I) One member representing a system of care, as defined in ORS 418.976;

37 (J) One consumer representative;

38 (K) One representative of a tribal government;

39 (L) One representative of an organization that advocates on behalf of individuals with intellec-
40 tual or developmental disabilities;

41 (M) One representative of providers of behavioral health services;

42 (N) The director of the division of the **Oregon Health** authority responsible for behavioral
43 health services, as a nonvoting member;

44 (O) The Director of the Alcohol and Drug Policy Commission appointed under ORS 430.220, as
45 a nonvoting member;

1 (P) The authority’s Medicaid director, as a nonvoting member;

2 (Q) A representative of the Department of Human Services, as a nonvoting member; and

3 (R) Any other member that the director deems appropriate.

4 (b) The [board] office may modify the membership of the committee as needed.

5 (c) The division of the authority responsible for behavioral health services and the director of
6 the division shall staff the committee.

7 (d) The committee, in collaboration with the Health Plan Quality Metrics Committee, as needed,
8 shall:

9 (A) Establish quality metrics for behavioral health services provided by coordinated care or-
10 ganizations, health care providers, counties and other government entities; and

11 (B) Establish incentives to improve the quality of behavioral health services.

12 (e) The quality metrics and incentives shall be designed to:

13 (A) Improve timely access to behavioral health care;

14 (B) Reduce hospitalizations;

15 (C) Reduce overdoses;

16 (D) Improve the integration of physical and behavioral health care; and

17 (E) Ensure individuals are supported in the least restrictive environment that meets their be-
18 havioral health needs.

19 (6) Members of the committees described in subsections (2) to (5) of this section [*who are not*
20 *members of the Oregon Health Policy Board*] are not entitled to compensation but shall be reim-
21 bursed from funds available to the [board] office for actual and necessary travel and other expenses
22 incurred by them by their attendance at committee meetings, in the manner and amount provided
23 in ORS 292.495.

24
25 **(Recruitment of Primary Care Providers)**

26
27 **SECTION 5.** ORS 413.231 is amended to read:

28 413.231. The [*Oregon Health Authority*] **Office of Health Care Affordability**, through the Health
29 Care Workforce Committee created pursuant to ORS 413.017, shall work with interested parties,
30 which may include Travel Oregon, the State Workforce and Talent Development Board, medical
31 schools, physician organizations, hospitals, county and city officials, local chambers of commerce,
32 organizations that promote Oregon or local communities in Oregon, and organizations that recruit
33 health care professionals, to develop a strategic plan for recruiting primary care providers to
34 Oregon. The strategic plan must address:

35 (1) Best recruitment practices and existing recruitment programs;

36 (2) Development of materials and information promoting Oregon as a desirable place for primary
37 care providers to live and work;

38 (3) Development of a pilot program to promote coordinated visiting and recruitment opportu-
39 nities for primary care providers;

40 (4) Potential funding opportunities; and

41 (5) The best entities to implement the strategic plan.

42 **SECTION 6.** ORS 413.248 is amended to read:

43 413.248. (1) The Physician Visa Waiver Program is established in the [*Oregon Health Authority*]
44 **Office of Health Care Affordability**. The purpose of the program is to make recommendations to
45 the United States Department of State for a waiver of the foreign country residency requirement

1 on behalf of foreign physicians holding visas who seek employment in federally designated shortage
2 areas.

3 (2) A foreign physician who has completed a residency in the United States may apply to the
4 [authority] office for a recommendation for a waiver of the foreign country residency requirement
5 in order to obtain employment in a federally designated shortage area in the state. Applications
6 shall be on the forms of and contain the information requested by the [authority] office. Each ap-
7 plication shall be accompanied by the application fee.

8 (3) The [authority] office reserves the right to recommend or decline to recommend any request
9 for a waiver.

10 (4) The [authority] office shall adopt rules necessary to implement and administer the program,
11 including but not limited to adopting an application fee not to exceed the cost of administering the
12 program.

13
14 **(Patient Centered Primary Care and Behavioral Health Home**
15 **Programs)**

16
17 **SECTION 7.** ORS 413.259 is amended to read:

18 413.259. (1) There is established in the [Oregon Health Authority] **Office of Health Care**
19 **Affordability** the patient centered primary care home program and the behavioral health home
20 program. Through these programs, the [authority] office shall:

21 (a) Define core attributes of a patient centered primary care home and a behavioral health home
22 to promote a reasonable level of consistency of services provided by patient centered primary care
23 homes and behavioral health homes in this state. In defining core attributes related to ensuring that
24 care is coordinated, the [authority] office shall focus on determining whether these patient centered
25 primary care homes and behavioral health homes offer comprehensive primary and preventive care,
26 integrated health care and disease management services;

27 (b) Establish a simple and uniform process to identify patient centered primary care homes and
28 behavioral health homes that meet the core attributes defined by the [authority] office under para-
29 graph (a) of this subsection;

30 (c) Develop uniform quality measures that build from nationally accepted measures and allow
31 for standard measurement of patient centered primary care home and behavioral health home per-
32 formance;

33 (d) Develop uniform quality measures for acute care hospital and ambulatory services that align
34 with the patient centered primary care home and behavioral health home quality measures devel-
35 oped under paragraph (c) of this subsection; and

36 (e) Develop policies that encourage the retention of, and the growth in the numbers of, primary
37 care providers.

38 (2)(a) The Director of the [Oregon Health Authority] **Office of Health Care Affordability** shall
39 appoint an advisory committee to advise the [authority] office in carrying out subsection (1) of this
40 section.

41 (b) The director shall appoint to the advisory committee 15 individuals who represent a diverse
42 constituency and are knowledgeable about patient centered primary care home delivery systems,
43 behavioral health home delivery systems, integrated health care or health care quality.

44 (c) Members of the advisory committee are not entitled to compensation, but may be reimbursed
45 for actual and necessary travel and other expenses incurred by them in the performance of their

1 official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall
 2 be paid out of funds appropriated to the [authority] office for the purposes of the advisory commit-
 3 tee.

4 (d) The advisory committee shall use public input to guide policy development.

5 (3) The [authority] office will also establish, as part of the patient centered primary care home
 6 program, learning collaboratives in which state agencies, private health insurance carriers, third
 7 party administrators, patient centered primary care homes and behavioral health homes can:

8 (a) Share information about quality improvement;

9 (b) Share best practices that increase access to culturally competent and linguistically appro-
 10 priate care;

11 (c) Share best practices that increase the adoption and use of the latest techniques in effective
 12 and cost-effective patient centered care;

13 (d) Coordinate efforts to develop and test methods to align financial incentives to support pa-
 14 tient centered primary care homes and behavioral health homes;

15 (e) Share best practices for maximizing the utilization of patient centered primary care homes
 16 and behavioral health homes by individuals enrolled in medical assistance programs, including cul-
 17 turally specific and targeted outreach and direct assistance with applications to adults and children
 18 of racial, ethnic and language minority communities and other underserved populations;

19 (f) Coordinate efforts to conduct research on patient centered primary care homes and behav-
 20 ioral health homes and evaluate strategies to implement patient centered primary care homes and
 21 behavioral health homes that include integrated health care to improve health status and quality
 22 and reduce overall health care costs; and

23 (g) Share best practices for maximizing integration to ensure that patients have access to com-
 24 prehensive primary and preventive care, integrated health care and disease management services.

25 (4) The Legislative Assembly declares that collaboration among public payers, private health
 26 carriers, third party purchasers and providers to identify appropriate reimbursement methods to
 27 align incentives in support of patient centered primary care homes and behavioral health homes is
 28 in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt
 29 from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and
 30 associated payment reforms designed and implemented under subsection (3) of this section that might
 31 otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or
 32 entity to engage in activities or to conspire to engage in activities that would constitute per se vi-
 33 olations of state or federal antitrust laws including, but not limited to, agreements among competing
 34 health care providers or health carriers as to the prices of specific levels of reimbursement for
 35 health care services.

36 (5) The [authority] office may contract with a public or private entity to facilitate the work of
 37 the learning collaborative described in subsection (3) of this section and may apply for, receive and
 38 accept grants, gifts, payments and other funds and advances, appropriations, properties and services
 39 from the United States, the State of Oregon or any governmental body or agency or from any other
 40 public or private corporation or person for the purpose of establishing and maintaining the
 41 collaborative.

42 **SECTION 8.** ORS 413.260 is amended to read:

43 413.260. (1) The [Oregon Health Authority] **Office of Health Care Affordability**, in collaboration
 44 with health insurers and purchasers of health plans including the Public Employees' Benefit Board,
 45 the Oregon Educators Benefit Board and other members of the patient centered primary care home

1 learning collaborative and the patient centered primary care home program advisory committee,
2 shall:

3 (a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans
4 for:

5 (A) Receiving care through patient centered primary care homes and behavioral health homes
6 that meet the core attributes established in ORS 413.259;

7 (B) Seeking preventative and wellness services;

8 (C) Practicing healthy behaviors; and

9 (D) Effectively managing chronic diseases.

10 (b) Develop, test and evaluate community-based strategies that utilize community health workers
11 to enhance the culturally competent and linguistically appropriate health services provided by pa-
12 tient centered primary care homes and behavioral health homes in underserved communities.

13 (2) The *[authority]* **office** shall focus on patients with chronic health conditions in developing
14 strategies under this section.

15 (3) The *[authority]* **office**, in collaboration with the Public Employees' Benefit Board and the
16 Oregon Educators Benefit Board, shall establish uniform standards for contracts with health benefit
17 plans providing coverage to public employees to promote the provision of patient centered primary
18 care homes, especially for enrollees with chronic medical conditions, and behavioral health homes
19 that are consistent with the uniform quality measures established under ORS 413.259 (1)(c).

20 (4) The standards established under subsection (3) of this section may direct health benefit plans
21 to provide incentives to primary care providers who serve vulnerable populations to partner with
22 health-focused community-based organizations to provide culturally specific health promotion and
23 disease management services.

24 **SECTION 9.** ORS 414.655 is amended to read:

25 414.655. (1) The *[Oregon Health Authority]* **Office of Health Care Affordability** shall establish
26 standards for the utilization of patient centered primary care homes and behavioral health homes
27 by coordinated care organizations.

28 (2) Each coordinated care organization shall implement, to the maximum extent feasible, patient
29 centered primary care homes and behavioral health homes, including developing capacity for ser-
30 vices in settings that are accessible to families, diverse communities and underserved populations,
31 including the provision of integrated health care. The organization shall require its other health and
32 services providers to communicate and coordinate care with the patient centered primary care home
33 or behavioral health home in a timely manner using electronic health information technology.

34 (3) Standards established by the *[authority]* **office** for the utilization of patient centered primary
35 care homes and behavioral health homes by coordinated care organizations may require the use of
36 federally qualified health centers, rural health clinics, school-based health clinics and other safety
37 net providers that qualify as patient centered primary care homes or behavioral health homes to
38 ensure the continued critical role of those providers in meeting the needs of underserved popu-
39 lations.

40 (4) In order to promote the full integration of behavioral health and physical health services in
41 primary care, behavioral health care and urgent care settings, providers in patient centered primary
42 care homes and behavioral health homes may use billing codes applicable to the behavioral health
43 and physical health services that are provided.

44 (5) Each coordinated care organization shall report to the *[authority]* **office** on uniform quality
45 measures prescribed by the *[authority]* **office** by rule for patient centered primary care homes and

1 behavioral health homes.

2 (6) Patient centered primary care homes and behavioral health homes must participate in the
3 learning collaborative described in ORS 413.259 (3).

4
5 **(Regulation of Material Change Transactions)**

6
7 **SECTION 10.** ORS 415.500 is amended to read:

8 415.500. As used in this section and ORS 415.501 and 415.505:

9 (1) “Corporate affiliation” has the meaning prescribed by the [*Oregon Health Authority*] **Office**
10 **of Health Care Affordability** by rule, including:

11 (a) Any relationship between two organizations that reflects, directly or indirectly, a partial or
12 complete controlling interest or partial or complete corporate control; and

13 (b) Transactions that merge tax identification numbers or corporate governance.

14 (2) “Essential services” means:

15 (a) Services that are funded on the prioritized list described in ORS 414.690; and

16 (b) Services that are essential to achieve health equity.

17 (3) “Health benefit plan” has the meaning given that term in ORS 743B.005.

18 (4)(a) “Health care entity” includes:

19 (A) An individual health professional licensed or certified in this state;

20 (B) A hospital, as defined in ORS 442.015, or hospital system, as defined by the [*authority*] **office**
21 by rule;

22 (C) A carrier, as defined in ORS 743B.005, that offers a health benefit plan in this state;

23 (D) A Medicare Advantage plan;

24 (E) A coordinated care organization or a prepaid managed care health services organization, as
25 both terms are defined in ORS 414.025; and

26 (F) Any other entity that has as a primary function the provision of health care items or ser-
27 vices or that is a parent organization of, or is an entity closely related to, an entity that has as a
28 primary function the provision of health care items or services.

29 (b) “Health care entity” does not include:

30 (A) Long term care facilities, as defined in ORS 442.015.

31 (B) Facilities licensed and operated under ORS 443.400 to 443.455.

32 (5) “Health equity” has the meaning prescribed by the Oregon Health Policy Board and adopted
33 by the [*authority*] **office** by rule.

34 (6)(a) “Material change transaction” means:

35 (A) A transaction in which at least one party had average revenue of \$25 million or more in the
36 preceding three fiscal years and another party:

37 (i) Had an average revenue of at least \$10 million in the preceding three fiscal years; or

38 (ii) In the case of a new entity, is projected to have at least \$10 million in revenue in the first
39 full year of operation at normal levels of utilization or operation as prescribed by the [*authority*]
40 **office** by rule.

41 (B) If a transaction involves a health care entity in this state and an out-of-state entity, a
42 transaction that otherwise qualifies as a material change transaction under this paragraph that may
43 result in increases in the price of health care or limit access to health care services in this state.

44 (b) “Material change transaction” does not include:

45 (A) A clinical affiliation of health care entities formed for the purpose of collaborating on clin-

1 ical trials or graduate medical education programs.

2 (B) A medical services contract or an extension of a medical services contract.

3 (C) An affiliation that:

4 (i) Does not impact the corporate leadership, governance or control of an entity; and

5 (ii) Is necessary, as prescribed by the [authority] **office** by rule, to adopt advanced value-based
6 payment methodologies to meet the health care cost growth targets under ORS 442.386.

7 (D) Contracts under which one health care entity, for and on behalf of a second health care
8 entity, provides patient care and services or provides administrative services relating to, supporting
9 or facilitating the provision of patient care and services, if the second health care entity:

10 (i) Maintains responsibility, oversight and control over the patient care and services; and

11 (ii) Bills and receives reimbursement for the patient care and services.

12 (E) Transactions in which a participant that is a health center as defined in 42 U.S.C. 254b,
13 while meeting all of the participant's obligations, acquires, affiliates with, partners with or enters
14 into any agreement with another entity unless the transaction would result in the participant no
15 longer qualifying as a health center under 42 U.S.C. 254b.

16 (7)(a) "Medical services contract" means a contract to provide medical or mental health services
17 entered into by:

18 (A) A carrier and an independent practice association;

19 (B) A carrier, coordinated care organization, independent practice association or network of
20 providers and one or more providers, as defined in ORS 743B.001;

21 (C) An independent practice association and an individual health professional or an organization
22 of health care providers;

23 (D) Medical, dental, vision or mental health clinics; or

24 (E) A medical, dental, vision or mental health clinic and an individual health professional to
25 provide medical, dental, vision or mental health services.

26 (b) "Medical services contract" does not include a contract of employment or a contract creat-
27 ing a legal entity and ownership of the legal entity that is authorized under ORS chapter 58, 60 or
28 70 or under any other law authorizing the creation of a professional organization similar to those
29 authorized by ORS chapter 58, 60 or 70, as may be prescribed by the [authority] **office** by rule.

30 (8) "Net patient revenue" means the total amount of revenue, after allowance for contractual
31 amounts, charity care and bad debt, received for patient care and services, including:

32 (a) Value-based payments;

33 (b) Incentive payments;

34 (c) Capitation payments or payments under any similar contractual arrangement for the pre-
35 payment or reimbursement of patient care and services; and

36 (d) Any payment received by a hospital to reimburse a hospital assessment under ORS 414.855.

37 (9) "Revenue" means:

38 (a) Net patient revenue; or

39 (b) The gross amount of premiums received by a health care entity that are derived from health
40 benefit plans.

41 (10) "Transaction" means:

42 (a) A merger of a health care entity with another entity;

43 (b) An acquisition of one or more health care entities by another entity;

44 (c) New contracts, new clinical affiliations and new contracting affiliations that will eliminate
45 or significantly reduce, as defined by the [authority] **office** by rule, essential services;

1 (d) A corporate affiliation involving at least one health care entity; or

2 (e) Transactions to form a new partnership, joint venture, accountable care organization, parent
3 organization or management services organization, as prescribed by the [authority] office by rule.

4 **SECTION 11.** ORS 415.501 is amended to read:

5 415.501. (1) The purpose of this section is to promote the public interest and to advance the
6 goals set forth in ORS 414.018 and the goals of the Oregon Integrated and Coordinated Health Care
7 Delivery System described in ORS 414.570.

8 (2) In accordance with subsection (1) of this section, the [Oregon Health Authority] **Office of**
9 **Health Care Affordability** shall adopt by rule criteria approved by the Oregon Health Policy Board
10 for the consideration of requests by health care entities to engage in a material change transaction
11 and procedures for the review of material change transactions under this section.

12 (3)(a) A notice of a material change transaction involving the sale, merger or acquisition of a
13 domestic health insurer shall be submitted to the Department of Consumer and Business Services
14 as an addendum to filings required by ORS 732.517 to 732.546 or 732.576. The department shall
15 provide to the [authority] office the notice submitted under this subsection to enable the
16 [authority] office to conduct a review in accordance with subsections (5) and (7) of this section. The
17 [authority] office shall notify the department of the outcome of the [authority's] office's review.

18 (b) The department shall make the final determination in material change transactions involving
19 the sale, merger or acquisition of a domestic health insurer and shall coordinate with the
20 [authority] office to incorporate the [authority's] office's review into the department's final deter-
21 mination.

22 (4) An entity shall submit to the [authority] office a notice of a material change transaction,
23 other than a transaction described in subsection (3) of this section, in the form and manner pre-
24 scribed by the [authority] office, no less than 180 days before the date of the transaction and shall
25 pay a fee prescribed in ORS 415.512.

26 (5) No later than 30 days after receiving a notice described in subsections (3) and (4) of this
27 section, the [authority] office shall conduct a preliminary review to determine if the transaction has
28 the potential to have a negative impact on access to affordable health care in this state and meets
29 the criteria in subsection (9) of this section.

30 (6) Following a preliminary review, the [authority] office or the department shall approve a
31 transaction or approve a transaction with conditions designed to further the goals described in
32 subsection (1) of this section based on criteria prescribed by the [authority] office by rule, including
33 but not limited to:

34 (a) If the transaction is in the interest of consumers and is urgently necessary to maintain the
35 solvency of an entity involved in the transaction; or

36 (b) If the [authority] office determines that the transaction does not have the potential to have
37 a negative impact on access to affordable health care in this state or the transaction is likely to
38 meet the criteria in subsection (9) of this section.

39 (7)(a) Except as provided in paragraph (b) of this subsection, if a transaction does not meet the
40 criteria in subsection (6) of this section, the [authority] office shall conduct a comprehensive review
41 and may appoint a review board of stakeholders to conduct a comprehensive review and make rec-
42 ommendations as provided in subsections (11) to (18) of this section. The [authority] office shall
43 complete the comprehensive review no later than 180 days after receipt of the notice unless the
44 parties to the transaction agree to an extension of time.

45 (b) The [authority] office or the department may intervene in a transaction described in ORS

1 415.500 [(6)(a)(C)] **(6)(a)(B)** in which the final authority rests with another state and, if the trans-
2 action is approved by the other state, may place conditions on health care entities operating in this
3 state with respect to the insurance or health care industry market in this state, prices charged to
4 patients residing in this state and the services available in health care facilities in this state, to
5 serve the public good.

6 (8) The [authority] **office** shall prescribe by rule:

7 (a) Criteria to exempt an entity from the requirements of subsection (4) of this section if there
8 is an emergency situation that threatens immediate care services and the transaction is urgently
9 needed to protect the interest of consumers;

10 (b) Provision for the [authority's] **office's** failure to complete a review under subsection (5) of
11 this section within 30 days; and

12 (c) Criteria for when to conduct a comprehensive review and appoint a review board under
13 subsection (7) of this section that must include, but is not limited to:

14 (A) The potential loss or change in access to essential services;

15 (B) The potential to impact a large number of residents in this state; or

16 (C) A significant change in the market share of an entity involved in the transaction.

17 (9) A health care entity may engage in a material change transaction if, following a compre-
18 hensive review conducted by the [authority] **office** and recommendations by a review board ap-
19 pointed under subsection (7) of this section, the [authority] **office** determines that the transaction
20 meets the criteria adopted by the [department] **office** by rule under subsection (2) of this section and:

21 (a)(A) The parties to the transaction demonstrate that the transaction will benefit the public
22 good and communities by:

23 (i) Reducing the growth in patient costs in accordance with the health care cost growth targets
24 established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the
25 entity demonstrates is the best interest of the public;

26 (ii) Increasing access to services in medically underserved areas; or

27 (iii) Rectifying historical and contemporary factors contributing to a lack of health equities or
28 access to services; or

29 (B) The transaction will improve health outcomes for residents of this state; and

30 (b) There is no substantial likelihood of anticompetitive effects from the transaction that out-
31 weigh the benefits of the transaction in increasing or maintaining services to underserved popu-
32 lations.

33 (10) The [authority] **office** may suspend a proposed material change transaction if necessary to
34 conduct an examination and complete an analysis of whether the transaction is consistent with
35 subsection (9) of this section and the criteria adopted by rule under subsection (2) of this section.

36 (11)(a) A review board convened by the [authority] **office** under subsection (7) of this section
37 must consist of members of the affected community, consumer advocates and health care experts.
38 No more than one-third of the members of the review board may be representatives of institutional
39 health care providers. The [authority] **office** may not appoint to a review board an individual who
40 is employed by an entity that is a party to the transaction that is under review or is employed by
41 a competitor that is of a similar size to an entity that is a party to the transaction.

42 (b) A member of a review board shall file a notice of conflict of interest and the notice shall
43 be made public.

44 (12) The [authority] **office** may request additional information from an entity that is a party to
45 the material change transaction, and the entity shall promptly reply using the form of communi-

1 cation requested by the [authority] **office** and verified by an officer of the entity if required by the
2 [authority] **office**.

3 (13)(a) An entity may not refuse to provide documents or other information requested under
4 subsection (4) or (12) of this section on the grounds that the information is confidential.

5 (b) Material that is privileged or confidential may not be publicly disclosed if:

6 (A) The [authority] **office** determines that disclosure of the material would cause harm to the
7 public;

8 (B) The material may not be disclosed under ORS 192.311 to 192.478; or

9 (C) The material is not subject to disclosure under ORS 705.137.

10 (c) The [authority] **office** shall maintain the confidentiality of all confidential information and
11 documents that are not publicly available that are obtained in relation to a material change trans-
12 action and may not disclose the information or documents to any person, including a member of the
13 review board, without the consent of the person who provided the information or document. Infor-
14 mation and documents described in this paragraph are exempt from disclosure under ORS 192.311
15 to 192.478.

16 (14) The [authority] **office** or the Department of Justice may retain actuaries, accountants or
17 other professionals independent of the [authority] **office** who are qualified and have expertise in the
18 type of material change transaction under review as necessary to assist the [authority] **office** in
19 conducting the analysis of a proposed material change transaction. The [authority] **office** or the
20 Department of Justice shall designate the party or parties to the material change transaction that
21 shall bear the reasonable and actual cost of retaining the professionals.

22 (15) A review board may hold up to two public hearings to seek public input and otherwise en-
23 gage the public before making a determination on the proposed transaction. A public hearing must
24 be held in the service area or areas of the health care entities that are parties to the material
25 change transaction. At least 10 days prior to the public hearing, the [authority] **office** shall post to
26 the [authority's] **office's** website information about the public hearing and materials related to the
27 material change transaction, including:

28 (a) A summary of the proposed transaction;

29 (b) An explanation of the groups or individuals likely to be impacted by the transaction;

30 (c) Information about services currently provided by the health care entity, commitments by the
31 health care entity to continue such services and any services that will be reduced or eliminated;

32 (d) Details about the hearings and how to submit comments, in a format that is easy to find and
33 easy to read; and

34 (e) Information about potential or perceived conflicts of interest among executives and members
35 of the board of directors of health care entities that are parties to the transaction.

36 (16) The [authority] **office** shall post the information described in subsection (15)(a) to (d) of this
37 section to the [authority's] **office's** website in the languages spoken in the area affected by the ma-
38 terial change transaction and in a culturally sensitive manner.

39 (17) The [authority] **office** shall provide the information described in subsection (15)(a) to (d) of
40 this section to:

41 (a) At least one newspaper of general circulation in the area affected by the material change
42 transaction;

43 (b) Health facilities in the area affected by the material change transaction for posting by the
44 health facilities; and

45 (c) Local officials in the area affected by the material change transaction.

1 (18) A review board shall make recommendations to the [authority] **office** to approve the mate-
 2 rial change transaction, disapprove the material change transaction or approve the material change
 3 transaction subject to conditions, based on subsection (9) of this section and the criteria adopted
 4 by rule under subsection (2) of this section. The [authority] **office** shall issue a proposed order and
 5 allow the parties and the public a reasonable opportunity to make written exceptions to the pro-
 6 posed order. The [authority] **office** shall consider the parties' and the public's written exceptions and
 7 issue a final order setting forth the [authority's] **office's** findings and rationale for adopting or
 8 modifying the recommendations of the review board. If the [authority] **office** modifies the recom-
 9 mendations of the review board, the [authority] **office** shall explain the modifications in the final
 10 order and the reasons for the modifications. A party to the material change transaction may contest
 11 the final order as provided in ORS chapter 183.

12 (19) A health care entity that is a party to an approved material change transaction shall notify
 13 the [authority] **office** upon the completion of the transaction in the form and manner prescribed by
 14 the [authority] **office**. One year, two years and five years after the material change transaction is
 15 completed, the [authority] **office** shall analyze:

16 (a) The health care entities' compliance with conditions placed on the transaction, if any;

17 (b) The cost trends and cost growth trends of the parties to the transaction; and

18 (c) The impact of the transaction on the health care cost growth target established under ORS
 19 442.386.

20 (20) The [authority] **office** shall publish the [authority's] **office's** analyses and conclusions under
 21 subsection (19) of this section and shall incorporate the [authority's] **office's** analyses and conclu-
 22 sions under subsection (19) of this section in the report described in ORS 442.386 (6).

23 (21) This section does not impair, modify, limit or supersede the applicability of ORS 65.800 to
 24 65.815, 646.605 to 646.652 or 646.705 to 646.805.

25 (22) Whenever it appears to the Director of the [*Oregon Health Authority*] **Office of Health**
 26 **Care Affordability** that any person has committed or is about to commit a violation of this section
 27 or any rule or order issued by the [authority] **office** under this section, the director may apply to
 28 the Circuit Court for Marion County for an order enjoining the person, and any director, officer,
 29 employee or agent of the person, from the violation, and for such other equitable relief as the nature
 30 of the case and the interest of the public may require.

31 (23) The remedies provided under this section are in addition to any other remedy, civil or
 32 criminal, that may be available under any other provision of law.

33 (24) The [authority] **office** may adopt rules necessary to carry out the provisions of this section.

34 **SECTION 12.** ORS 415.505 is amended to read:

35 415.505. (1) An officer or employee of the [*Oregon Health Authority*] **Office of Health Care**
 36 **Affordability** who is delegated responsibilities in the enforcement of ORS 415.501 or rules adopted
 37 pursuant to ORS 415.501 may not:

38 (a) Be a director, officer or employee of or be financially interested in an entity that is a party
 39 to a proposed material change transaction except as an enrollee or patient of a health care entity
 40 or by reason of rights vested in compensation or benefits related to services performed prior to af-
 41 filiation with the [authority] **office**; or

42 (b) Be engaged in any other business or occupation interfering with or inconsistent with the
 43 duties of the [authority] **office**.

44 (2) This section does not permit any conduct, affiliation or interest that is otherwise prohibited
 45 by public policy.

SECTION 13. ORS 415.510 is amended to read:

415.510. Every four years, the [*Oregon Health Authority*] **Office of Health Care Affordability** shall commission a study of the impact of health care consolidation in this state. The study must review consolidation occurring during the previous four-year period and include an analysis of:

(1) The impact on costs to consumers for health care either to the benefit or the detriment of consumers; and

(2) Any increases or decreases in the quality of care, including:

(a) Improvement or reductions in morbidity;

(b) Improvement or reductions in the management of population health; **or**

(c) Changes to health and patient outcomes, particularly for underserved and uninsured individuals, recipients of medical assistance and other low-income individuals and individuals living in rural areas, as measured by nationally recognized measures of the quality of health care, such as measures used or endorsed by the National Committee for Quality Assurance, the National Quality Forum, the Physician Consortium for Performance Improvement or the Agency for Healthcare Research and Quality.

SECTION 14. Section 6a, chapter 615, Oregon Laws 2021, is amended to read:

Sec. 6a. The [*Oregon Health Authority*] **Office of Health Care Affordability** shall commission the first study under [*section 6 of this 2021 Act*] **ORS 415.510** no later than September 15, 2026.

SECTION 15. ORS 415.512 is amended to read:

415.512. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** shall prescribe by rule a fee to be paid under ORS 415.501 (3), proportionate to the size of the parties to the transaction, sufficient to reimburse the costs of administering ORS 415.501.

(2) Moneys received by the [*authority*] **office** under this section shall be deposited to the [*Oregon Health Authority*] **Health Care Affordability** Fund established in [*ORS 413.101*] **section 3 of this 2023 Act** to be used for carrying out ORS 415.501.

SECTION 16. A person may not file or cause to be filed with the Office of Health Care Affordability any article, certificate, report, statement, application or other information required or permitted to be filed under ORS 415.501 or rules adopted pursuant to ORS 415.501 that is known by the person to be false or misleading in any material respect.

SECTION 17. ORS 415.900 is amended to read:

415.900. (1) In addition to any other penalty imposed by law, the Director of the [*Oregon Health Authority*] **Office of Health Care Affordability** may impose a civil penalty, as determined by the director, for a violation of ORS [*413.037 or*] 415.501. The amount of the civil penalty may not exceed \$10,000 for each offense. The civil penalty imposed on an individual health professional may not exceed \$1,000 for each offense.

(2) Civil penalties shall be imposed and enforced in accordance with ORS 183.745.

(3) Moneys received by the [*Oregon Health Authority*] **office** under this section shall be paid to the State Treasury and credited to the General Fund.

SECTION 18. Section 19 of this 2023 Act is added to and made a part of ORS chapter 413.

SECTION 19. (1) In addition to any other penalty imposed by law, the Director of the Oregon Health Authority may impose a civil penalty, as determined by the director, for a violation of ORS 413.037. The amount of the civil penalty may not exceed \$10,000 for each offense. The civil penalty imposed on an individual health professional may not exceed \$1,000 for each offense.

(2) Civil penalties shall be imposed and enforced in accordance with ORS 183.745.

1 **(3) Moneys received by the Oregon Health Authority under this section shall be paid to**
2 **the State Treasury and credited to the General Fund.**

3
4 **(Reimbursement for Costs of Newborn Nurse Home Visiting Services)**

5
6 **SECTION 20.** ORS 433.301, as amended by section 59, chapter 631, Oregon Laws 2021, and
7 section 2, chapter 94, Oregon Laws 2022, is amended to read:

8 433.301. (1) As used in this section, “community” means a geographic region, county, tribe or
9 other group of individuals living in proximity as defined by the Oregon Health Authority by rule.

10 (2) The authority shall design, implement and maintain a voluntary statewide program to provide
11 universal newborn nurse home visiting services to all families with newborns residing in this state
12 to support healthy child development and strengthen families. The authority shall design the uni-
13 versal newborn nurse home visiting program to be flexible so as to meet the needs of the commu-
14 nities where the program operates.

15 (3) In designing the program described in subsection (2) of this section, the authority shall con-
16 sult, coordinate and collaborate, as necessary, with insurers that offer health benefit plans in this
17 state, hospitals, local public health authorities, the Department of Early Learning and Care, existing
18 early childhood home visiting programs, community-based organizations and social service providers.

19 (4) The program must provide nurse home visiting services that are:

20 (a) Based on criteria established by the United States Department of Health and Human Ser-
21 vices for an evidence-based early childhood home visiting service delivery model;

22 (b) Provided by registered nurses licensed in this state to families caring for newborns up to the
23 age of six months, including foster and adoptive newborns;

24 (c) Provided in the family’s home; and

25 (d) Aimed at improving outcomes in one or more of the following domains:

26 (A) Child health;

27 (B) Child development and school readiness;

28 (C) Family economic self-sufficiency;

29 (D) Maternal health;

30 (E) Positive parenting;

31 (F) Reducing child mistreatment;

32 (G) Reducing juvenile delinquency;

33 (H) Reducing family violence; or

34 (I) Reducing crime.

35 (5) The services provided in the program must:

36 (a) Be voluntary and carry no negative consequences for a family that declines to participate;

37 (b) Be offered in every community in this state;

38 (c) Include an evidence-based assessment of the physical, social and emotional factors affecting
39 the family;

40 (d) Be offered to all families with newborns residing in the community where the program op-
41 erates;

42 (e) Include at least one visit during a newborn’s first three months of life with the opportunity
43 for the family to choose up to three additional visits;

44 (f) Include a follow-up visit no later than three months after the last visit; and

45 (g) Provide information and referrals to address each family’s identified needs.

1 (6) The authority shall collect and analyze data generated by the program to assess the effec-
 2 tiveness of the program in meeting the aims described in subsection (4)(d) of this section and shall
 3 work with other state agencies to develop protocols for sharing data, including the timely sharing
 4 of data with primary care providers of care to the families with newborns receiving the services.

5 (7) In collaboration with the Department of Consumer and Business Services, the authority shall
 6 adopt by rule, consistent with the provisions of this section[.],

7 [(a)] criteria for universal newborn nurse home visiting services that must be covered by health
 8 benefit plans in accordance with ORS 743A.078[; and]

9 [(b) *The amount of reimbursement to be paid to a provider of universal newborn nurse home vis-
 10 iting services or a methodology to reimburse the cost of providing universal newborn nurse home vis-
 11 iting services, in accordance with ORS 743A.078.*]

12 (8) *[The authority may prescribe by rule]* **The Office of Health Care Affordability, in collab-
 13 oration with the department and the authority, shall adopt by rule:**

14 (a) **The amount of reimbursement to be paid to a provider of universal newborn nurse
 15 home visiting services or a methodology to reimburse the cost of providing universal new-
 16 born nurse home visiting services, in accordance with ORS 743A.078.**

17 (b) **The reimbursement prescribed under this subsection may use** any reasonable re-
 18 imbursement methodology including, but not limited to, any of the following:

19 [(a)] (A) Value-based payments;

20 [(b)] (B) A claim invoicing process;

21 [(c)] (C) Capitated payments;

22 [(d)] (D) A reimbursement methodology that takes into account the need for a community-based
 23 entity providing universal newborn nurse home visiting services to expand the entity’s capacity to
 24 provide the services and address health disparities; or

25 [(e)] (E) Any other methodology agreed to by a carrier and the provider of the universal new-
 26 born nurse home visiting services.

27
 28 **(Certificate of Need)**
 29

30 **SECTION 21.** ORS 442.315 is amended to read:

31 442.315. (1) Any new hospital or new skilled nursing or intermediate care service or facility not
 32 excluded pursuant to ORS 441.065 shall obtain a certificate of need from the [*Oregon Health Au-
 33 thority*] **Office of Health Care Affordability** prior to an offering or development.

34 (2) The [*authority*] **office** shall adopt rules specifying criteria and procedures for making deci-
 35 sions as to the need for the new services or facilities.

36 (3)(a) An applicant for a certificate of need shall apply to the [*authority*] **office** on forms pro-
 37 vided for this purpose by **the** [*authority rule*] **office**.

38 (b) An applicant shall pay a fee prescribed as provided in this section. Subject to the approval
 39 of the Oregon Department of Administrative Services, the [*authority*] **office** shall prescribe applica-
 40 tion fees, based on the complexity and scope of the proposed project.

41 (4)(a) The [*authority*] **office** shall issue a draft recommendation in response to an application for
 42 a certificate of need.

43 (b) The [*authority*] **office** may establish an expedited review process for an application for a
 44 certificate of need to rebuild a long term care facility, relocate buildings that are part of a long term
 45 care facility or relocate long term care facility bed capacity from one long term care facility to

1 another. The [authority] **office** shall issue a draft recommendation not later than 120 days after the
2 date a complete application subject to expedited review is received by the [authority] **office**.

3 (5)(a) An applicant or any affected person who is dissatisfied with the draft recommendation of
4 the [authority] **office** is entitled to an informal hearing before the [authority] **office** in the course
5 of review and before a proposed decision is rendered. Following an informal hearing, or if no appli-
6 cant or affected person requests an informal hearing within a period of time prescribed by the [au-
7 thority] **office** by rule, the [authority] **office** shall issue a proposed decision.

8 (b) An applicant or affected person is entitled to a contested case hearing in accordance with
9 ORS chapter 183 to challenge the proposed decision of the [authority] **office**. Following a contested
10 case hearing, or if no applicant or affected person requests a contested case hearing within a period
11 of time prescribed by the [authority] **office** by rule, the [authority] **office** shall issue a final order
12 granting, with or without limitations, or denying the certificate of need.

13 (6) Once a certificate of need has been granted, it may not be revoked or rescinded unless it
14 was acquired by fraud or deceit. However, if the [authority] **office** finds that a person is offering
15 or developing a project that is not within the scope of the certificate of need, the [authority] **office**
16 may limit the project as specified in the granted certificate of need or reconsider the application.
17 A certificate of need is not transferable.

18 (7) Nothing in this section applies to any hospital, skilled nursing or intermediate care service
19 or facility that seeks to replace equipment with equipment of similar basic technological function
20 or an upgrade that improves the quality or cost-effectiveness of the service provided. Any person
21 acquiring such replacement or upgrade shall file a letter of intent for the project in accordance with
22 the rules of the [authority] **office** if the price of the replacement equipment or upgrade exceeds \$1
23 million.

24 (8) Except as required in subsection (1) of this section for a new hospital or new skilled nursing
25 or intermediate care service or facility not operating as a Medicare swing bed program, nothing in
26 this section requires a rural hospital as defined in ORS 442.470 (6)(a)(A) and (B) to obtain a certif-
27 icate of need.

28 (9) Nothing in this section applies to basic health services, but basic health services do not in-
29 clude:

- 30 (a) Magnetic resonance imaging scanners;
- 31 (b) Positron emission tomography scanners;
- 32 (c) Cardiac catheterization equipment;
- 33 (d) Megavoltage radiation therapy equipment;
- 34 (e) Extracorporeal shock wave lithotriptors;
- 35 (f) Neonatal intensive care;
- 36 (g) Burn care;
- 37 (h) Trauma care;
- 38 (i) Inpatient psychiatric services;
- 39 (j) Inpatient chemical dependency services;
- 40 (k) Inpatient rehabilitation services;
- 41 (L) Open heart surgery; or
- 42 (m) Organ transplant services.

43 (10) In addition to any other remedy provided by law, whenever it appears that any person is
44 engaged in, or is about to engage in, any acts that constitute a violation of this section, or any rule
45 or order issued by the [authority] **office** under this section, the [authority] **office** may institute pro-

1 ceedings in the circuit courts to enforce obedience to such statute, rule or order by injunction or
 2 by other processes, mandatory or otherwise.

3 (11) As used in this section, “basic health services” means health services offered in or through
 4 a hospital licensed under ORS chapter 441, except skilled nursing or intermediate care nursing fa-
 5 cilities or services and those services specified in subsection (9) of this section.

6 **SECTION 22.** ORS 442.325 is amended to read:

7 442.325. (1) A certificate of need shall be required for the development or establishment of a
 8 health care facility of any new health maintenance organization.

9 (2) Any activity of a health maintenance organization which does not involve the direct delivery
 10 of health services, as distinguished from arrangements for indirect delivery of health services
 11 through contracts with providers, shall be exempt from certificate of need review.

12 (3) Nothing in ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and 442.450 applies
 13 to any decision of a health maintenance organization involving its organizational structure, its ar-
 14 rangements for financing health services, the terms of its contracts with enrolled beneficiaries or
 15 its scope of benefits.

16 (4) With the exception of certificate of need requirements, when applicable, the licensing and
 17 regulation of health maintenance organizations shall be controlled by ORS 750.005 to 750.095 and
 18 statutes incorporated by reference therein.

19 (5) It is the policy of ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and 442.450 to
 20 encourage the growth of health maintenance organizations as an alternative delivery system and to
 21 provide the facilities for the provision of quality health care to the present and future members who
 22 may enroll within their defined service area.

23 (6)(a) It is also the policy of ORS 244.050, 431.250, 441.015 to 441.087, 442.015 to 442.420 and
 24 442.450 to consider the special needs and circumstances of health maintenance organizations. Such
 25 needs and circumstances include the needs of and costs to members and projected members of the
 26 health maintenance organization in obtaining health services and the potential for a reduction in the
 27 use of inpatient care in the community through an extension of preventive health services and the
 28 provision of more systematic and comprehensive health services. The consideration of a new health
 29 service proposed by a health maintenance organization shall also address the availability and cost
 30 of obtaining the proposed new health service from the existing providers in the area that are not
 31 health maintenance organizations.

32 (b) The [*Oregon Health Authority*] **Office of Health Care Affordability** shall issue a certificate
 33 of need for beds, services or equipment to meet the needs or reasonably anticipated needs of mem-
 34 bers of health maintenance organizations when beds, services or equipment are not available from
 35 nonplan providers.

36 **SECTION 23.** ORS 442.342 is amended to read:

37 442.342. (1) Notwithstanding any other provision of law, a hospital licensed under ORS 441.025,
 38 in accordance with rules adopted by the Oregon Health Authority, may apply for waiver from the
 39 provisions of ORS 442.325, and the [*authority*] **Office of Health Care Affordability** shall grant the
 40 waiver if, for the most recently completed hospital fiscal year preceding the date of application for
 41 waiver and each succeeding fiscal year thereafter, the percentage of qualified inpatient revenue is
 42 not less than that described in subsection (2) of this section.

43 (2)(a) The percentage of qualified inpatient revenue for the first year in which a hospital is
 44 granted a waiver under subsection (1) of this section may not be less than 60 percent.

45 (b) The percentage in paragraph (a) of this subsection shall be increased by five percentage

1 points in each succeeding hospital fiscal year until the percentage of qualified inpatient revenue
 2 equals or exceeds 75 percent.

3 (3) As used in this section:

4 (a) “Qualified inpatient revenue” means revenue earned from public and private payers for in-
 5 patient hospital services approved by the [authority] office pursuant to rules, including:

6 (A) Revenue earned pursuant to Title XVIII, United States Social Security Act, when such re-
 7 venue is based on diagnostic related group prices that include capital-related expenses or other
 8 risk-based payment programs as approved by the [authority] office;

9 (B) Revenue earned pursuant to Title XIX, United States Social Security Act, when such revenue
 10 is based on diagnostic related group prices that include capital-related expenses;

11 (C) Revenue earned under negotiated arrangements with public or private payers based on all-
 12 inclusive per diem rates for one or more hospital service categories;

13 (D) Revenue earned under negotiated arrangements with public or private payers based on all-
 14 inclusive per discharge or per admission rates related to diagnostic related groups or other service
 15 or intensity-related measures;

16 (E) Revenue earned under arrangements with one or more health maintenance organizations; or

17 (F) Other prospectively determined forms of inpatient hospital reimbursement approved in ad-
 18 vance by the [authority] office in accordance with rules.

19 (b) “Percentage of qualified inpatient revenue” means qualified inpatient revenue divided by
 20 total gross inpatient revenue as defined by administrative rule of the [authority] office.

21 (4)(a) The [authority] office shall hold a hearing to determine the cause if any hospital granted
 22 a waiver pursuant to subsection (1) of this section fails to reach the applicable percentage of qual-
 23 ified inpatient revenue in any subsequent fiscal year of the hospital.

24 (b) If the [authority] office finds that the failure was without just cause and that the hospital
 25 has undertaken projects that, except for the provisions of this section, would have been subject to
 26 ORS 442.325, the [authority] office shall impose one of the penalties outlined in paragraph (c) of this
 27 subsection.

28 (c)(A) A one-time civil penalty of not less than \$25,000 or more than \$250,000; or

29 (B) An annual civil penalty equal to an amount not to exceed 110 percent of the net profit de-
 30 rived from such project or projects for a period not to exceed five years.

31 (5) Nothing in this section shall be construed to permit a hospital to develop a new inpatient
 32 hospital facility or provide new services authorized by facilities defined as “long term care
 33 facility” under ORS 442.015 under a waiver granted pursuant to subsection (1) of this section.

34
 35 **(Reporting of Proposed Capital Projects)**

36
 37 **SECTION 24.** ORS 442.362 is amended to read:

38 442.362. The [Oregon Health Authority] Office of Health Care Affordability may adopt rules
 39 requiring reporting entities within the state to publicly report proposed capital projects. Rules
 40 adopted under this section must:

41 (1) Require a reporting entity to establish on the home page of its website a prominently labeled
 42 link to information about proposed or pending capital projects. The information posted must include
 43 but is not limited to a report of the community benefit for the project, its estimated cost and a
 44 means for interested persons to submit comments. When a reporting entity posts the information
 45 required under this subsection, the reporting entity must notify the [authority] office of the posting

1 in the manner prescribed by the [authority] office.

2 (2) If a reporting entity does not have a website, require the reporting entity to publish notice
 3 of the proposed capital project in a major newspaper or online equivalent serving the region in
 4 which the proposed capital project will be located. The notice must include but is not limited to a
 5 report of the community benefit for the project, its estimated cost and a means for interested per-
 6 sons to submit comments. When a reporting entity publishes the information required under this
 7 subsection, the reporting entity must notify the [authority] office of the publication in the manner
 8 prescribed by the [authority] office.

9 (3) Establish a publicly available resource for information collected under this section.

10 **SECTION 25.** ORS 442.991 is amended to read:

11 442.991. (1) Any reporting entity that fails to report as required by rules of the [Oregon Health
 12 Authority] Office of Health Care Affordability adopted pursuant to ORS 442.362 may be subject
 13 to a civil penalty.

14 (2) The [authority] office shall adopt a schedule of penalties, not to exceed \$500 per day of vio-
 15 lation, that are based on the severity of the violation.

16 (3) Civil penalties imposed under this section shall be imposed as provided in ORS 183.745.

17 (4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and
 18 conditions as the [authority] office considers proper and consistent with the public health and safety.

19 (5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose
 20 of rate determination or for reimbursement by a third-party payer.

21
 22 **(Collection and Sharing of Health Care Data)**

23
 24 **SECTION 26.** ORS 442.370 is amended to read:

25 442.370. (1) In order to provide data essential for health planning programs:

26 (a) The Oregon Health Authority shall obtain directly from each hospital licensed to operate in
 27 this state, or from a third party working on behalf of or by contract with the hospital, the following
 28 information prescribed by the authority by rule:

- 29 (A) Ambulatory surgery discharge abstract records;
- 30 (B) Inpatient discharge abstract records; and
- 31 (C) Emergency department discharge abstract records.

32 (b) The authority shall obtain directly from each ambulatory surgical center licensed to operate
 33 in this state, or from a third party working on behalf of or by contract with the ambulatory surgical
 34 center, the following information prescribed by the authority by rule:

- 35 (A) Ambulatory surgery discharge abstract records; and
- 36 (B) Discharge abstract records of patients discharged from extended stay centers licensed under
 37 ORS 441.026 that are affiliated with the ambulatory surgical center.

38 (2) The authority may establish by rule a fee to be charged to each ambulatory surgical center.

39 (3) The fee established under subsection (2) of this section may not exceed the cost of abstract-
 40 ing and compiling the records.

41 (4) The authority may specify by rule the form in which records are to be submitted. If the form
 42 adopted by rule requires conversion from the form regularly used by a hospital, ambulatory surgical
 43 center or extended stay center, reasonable costs of such conversion shall be paid by the authority.

44 (5) The authority may provide by rule for the submission of ambulatory surgery, inpatient and
 45 emergency department discharge abstract records for enrollees in a health maintenance organization

1 in a form the authority determines appropriate to the authority's needs for the data and the
 2 organization's record keeping and reporting systems for charges and services.

3 (6) The authority shall notify any entity submitting data under this section of any changes to
 4 the data sets that must be submitted, no later than July 1 of the calendar year preceding the ef-
 5 fective date of the changes.

6 (7) The authority may contract with a third party to receive and process the records submitted
 7 under this section.

8 **(8) The authority shall provide to the Office of Health Care Affordability, upon request,**
 9 **any data received by the authority under this section that the office determines is necessary**
 10 **to carry out its duties.**

11 **SECTION 27.** ORS 442.373 is amended to read:

12 442.373. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** shall establish
 13 and maintain a program that requires reporting entities to report health care data for the following
 14 purposes:

15 (a) Determining the maximum capacity and distribution of existing resources allocated to health
 16 care.

17 (b) Identifying the demands for health care.

18 (c) Allowing health care policymakers to make informed choices.

19 (d) Evaluating the effectiveness of intervention programs in improving health outcomes.

20 (e) Comparing the costs and effectiveness of various treatment settings and approaches.

21 (f) Providing information to consumers and purchasers of health care.

22 (g) Improving the quality and affordability of health care and health care coverage.

23 (h) Assisting the [*authority*] **office** in furthering the health policies expressed by the Legislative
 24 Assembly in ORS 442.310.

25 (i) Evaluating health disparities, including but not limited to disparities related to race and
 26 ethnicity.

27 (2) The [*authority*] **office** shall prescribe by rule standards that are consistent with standards
 28 adopted by the Accredited Standards Committee X12 of the American National Standards Institute,
 29 the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug
 30 Programs that:

31 (a) Establish the time, place, form and manner of reporting data under this section, including
 32 but not limited to:

33 (A) Requiring the use of unique patient and provider identifiers;

34 (B) Specifying a uniform coding system that reflects all health care utilization and costs for
 35 health care services provided to Oregon residents in other states; and

36 (C) Establishing enrollment thresholds below which reporting will not be required.

37 (b) Establish the types of data to be reported under this section, including but not limited to:

38 (A) Health care claims and enrollment data used by reporting entities and paid health care
 39 claims data;

40 (B) Reports, schedules, statistics or other data relating to health care costs, prices, quality,
 41 utilization or resources determined by the [*authority*] **office** to be necessary to carry out the pur-
 42 poses of this section; and

43 (C) Data related to race, ethnicity and primary language collected in a manner consistent with
 44 established national standards.

45 (3) Any third party administrator that is not required to obtain a license under ORS 744.702 and

1 that is legally responsible for payment of a claim for a health care item or service provided to an
2 Oregon resident may report to the [authority] office the health care data described in subsection (2)
3 of this section.

4 (4) The [authority] office shall adopt rules establishing requirements for reporting entities to
5 train providers on protocols for collecting race, ethnicity and primary language data in a culturally
6 competent manner.

7 (5)(a) The [authority] office shall use data collected under this section to provide information to
8 consumers of health care to empower the consumers to make economically sound and medically
9 appropriate decisions. The information must include, but not be limited to, the prices and quality
10 of health care services.

11 (b) The [authority] office shall, using only data collected under this section from reporting en-
12 tities described in ORS 442.372 (1) to (3), post to its website health care price information including
13 the median prices paid by the reporting entities to hospitals and hospital outpatient clinics for, at
14 a minimum, the 50 most common inpatient procedures and the 100 most common outpatient proce-
15 dures.

16 (c) The health care price information posted to the website must be:

17 (A) Displayed in a consumer friendly format;

18 (B) Easily accessible by consumers; and

19 (C) Updated at least annually to reflect the most recent data available.

20 (d) The [authority] office shall apply for and receive donations, gifts and grants from any public
21 or private source to pay the cost of posting health care price information to its website in accord-
22 ance with this subsection. Moneys received shall be deposited to the [*Oregon Health Authority*
23 *Fund*] **Health Care Affordability Fund established in section 3 of this 2023 Act**.

24 (e) The obligation of the [authority] office to post health care price information to its website
25 as required by this subsection is limited to the extent of any moneys specifically appropriated for
26 that purpose or available from donations, gifts and grants from private or public sources.

27 (6) The [authority] office may contract with a third party to collect and process the health care
28 data reported under this section. The contract must prohibit the collection of Social Security num-
29 bers and must prohibit the disclosure or use of the data for any purpose other than those specifically
30 authorized by the contract. The contract must require the third party to transmit all data collected
31 and processed under the contract to the [authority] office.

32 (7) The [authority] office shall facilitate a collaboration between the Department of Human
33 Services, the [authority] office, the Department of Consumer and Business Services and interested
34 stakeholders to develop a comprehensive health care information system using the data reported
35 under this section and [collected] **obtained** by the [authority] office under ORS 442.370 and 442.400
36 to 442.463. The [authority] office, in consultation with interested stakeholders, shall:

37 (a) Formulate the data sets that will be included in the system;

38 (b) Establish the criteria and procedures for the development of limited use data sets;

39 (c) Establish the criteria and procedures to ensure that limited use data sets are accessible and
40 compliant with federal and state privacy laws; and

41 (d) Establish a time frame for the creation of the comprehensive health care information system.

42 (8) Information disclosed through the comprehensive health care information system described
43 in subsection (7) of this section:

44 (a) Shall be available, when disclosed in a form and manner that ensures the privacy and secu-
45 rity of personal health information as required by state and federal laws, as a resource to insurers,

1 employers, providers, purchasers of health care and state agencies to allow for continuous review
2 of health care utilization, expenditures and performance in this state;

3 (b) Shall be available to Oregon programs for quality in health care for use in improving health
4 care in Oregon, subject to rules prescribed by the [authority] office conforming to state and federal
5 privacy laws or limiting access to limited use data sets;

6 (c) Shall be presented to allow for comparisons of geographic, demographic and economic factors
7 and institutional size; and

8 (d) May not disclose trade secrets of reporting entities.

9 (9) The collection, storage and release of health care data and other information under this
10 section is subject to the requirements of the federal Health Insurance Portability and Accountability
11 Act.

12 (10)(a) Notwithstanding subsection (9) of this section, in addition to the comprehensive health
13 care information system described in subsection (7) of this section, the Department of Consumer and
14 Business Services shall be allowed to access, use and disclose data collected under this section by
15 certifying in writing that the data will be used only to carry out the department's duties.

16 (b) Personally identifiable information disclosed to the department under paragraph (a) of this
17 subsection, including a consumer's name, address, telephone number or electronic mail address, is
18 confidential and not subject to further disclosure under ORS 192.311 to 192.478.

19
20 **(Health Care Cost Growth Target Program)**

21
22 **SECTION 28.** ORS 442.386 is amended to read:

23 442.386. (1) The Legislative Assembly intends to establish a health care cost growth target, for
24 all providers and payers, to:

25 (a) Support accountability for the total cost of health care across all providers and payers, both
26 public and private;

27 (b) Build on the state's existing efforts around health care payment reform and containment of
28 health care costs; and

29 (c) Ensure the long-term affordability and financial sustainability of the health care system in
30 this state.

31 (2) The Health Care Cost Growth Target program is established. The program shall be admin-
32 istered by the [Oregon Health Authority] **Office of Health Care Affordability** in collaboration with
33 the Department of Consumer and Business Services, subject to the oversight of the Oregon Health
34 Policy Board. The program shall establish a health care cost growth target for increases in total
35 health expenditures and shall review and modify the target on a periodic basis.

36 (3) The health care cost growth target must:

37 (a) Promote a predictable and sustainable rate of growth for total health expenditures as meas-
38 ured by an economic indicator adopted by the board, such as the rate of increase in this state's
39 economy or of the personal income of residents of this state;

40 (b) Apply to all providers and payers in the health care system in this state;

41 (c) Use established economic indicators; and

42 (d) Be measurable on a per capita basis, statewide basis and health care entity basis.

43 (4) The program shall establish a methodology for calculating health care cost growth:

44 (a) Statewide;

45 (b) For each provider and payer, taking into account the health status of the patients of the

1 provider or the beneficiary of the payer; and

2 (c) Per capita.

3 (5) The program shall establish requirements for providers and payers to report data and other
4 information necessary to calculate health care cost growth under subsection (4) of this section.

5 (6) Annually, the program shall:

6 (a) Hold public hearings on the growth in total health expenditures in relation to the health care
7 cost growth in the previous calendar year;

8 (b) Publish a report on health care costs and spending trends that includes:

9 (A) Factors impacting costs and spending; and

10 (B) Recommendations for strategies to improve the efficiency of the health care system; and

11 (c) For providers and payers for which health care cost growth in the previous calendar year
12 exceeded the health care cost growth target:

13 (A) Analyze the cause for exceeding the health care cost growth target; and

14 (B) Require the provider or payer to develop and undertake a performance improvement plan.

15 (7)(a) The [authority] **office** shall adopt by rule criteria for waiving the requirement for a pro-
16 vider or payer to undertake a performance improvement plan, if necessitated by unforeseen market
17 conditions or other equitable factors.

18 (b) The [authority] **office** shall collaborate with a provider or payer that is required to develop
19 and undertake a performance improvement plan by:

20 (A) Providing a template for performance improvement plans, guidelines and a time frame for
21 submission of the plan;

22 (B) Providing technical assistance such as webinars, office hours, consultation with technical
23 assistance providers or staff, or other guidance; and

24 (C) Establishing a contact at the [authority] **office** who can work with the provider or payer in
25 developing the performance improvement plan.

26 (8) A performance improvement plan must:

27 (a) Identify key cost drivers and include concrete steps a provider or payer will take to address
28 the cost drivers;

29 (b) Identify an appropriate time frame by which a provider or payer will reduce the cost drivers
30 and be subject to an evaluation by the [authority] **office**; and

31 (c) Have clear measurements of success.

32 (9) The [authority] **office** shall adopt by rule criteria for imposing a financial penalty on any
33 provider or payer that exceeds the cost growth target without reasonable cause in three out of five
34 calendar years or on any provider or payer that does not participate in the program. The criteria
35 must be based on the degree to which the provider or payer exceeded the target and other factors,
36 including but not limited to:

37 (a) The size of the provider or payer organization;

38 (b) The good faith efforts of the provider or payer to address health care costs;

39 (c) The provider's or payer's cooperation with the [authority] **office** or the department;

40 (d) Overlapping penalties that may be imposed for failing to meet the target, such as require-
41 ments relating to medical loss ratios; and

42 (e) A provider's or payer's overall performance in reducing cost across all markets served by the
43 provider or payer.

44
45

(Standardized Payment Methodologies)

1 **SECTION 29.** ORS 442.392 is amended to read:

2 442.392. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** shall prescribe
3 by rule a uniform payment methodology for hospital and ambulatory surgical center services that:

4 (a) Incorporates the most recent Medicare payment methodologies established by the Centers for
5 Medicare and Medicaid Services, or similar payment methodologies, for hospital and ambulatory
6 surgical center services;

7 (b) Includes payment methodologies for services and equipment that are not fully addressed by
8 Medicare payment methodologies; and

9 (c) Allows for the use of alternative payment methodologies, including but not limited to pay-
10 for-performance, bundled payments and capitation.

11 (2) In developing the payment methodologies described in this section, the [*authority*] **office** shall
12 convene and be advised by a work group consisting of providers, insurers and consumers of the
13 types of health care services that are subject to the methodologies.

14 **SECTION 30.** ORS 442.394 is amended to read:

15 442.394. (1) A hospital or ambulatory surgical center shall bill and accept as payment in full an
16 amount determined in accordance with ORS 243.256 and 243.879, if applicable, or the payment
17 methodology prescribed by the [*Oregon Health Authority*] **Office of Health Care Affordability** un-
18 der ORS 442.392.

19 (2) This section does not apply to type A or type B hospitals, as described in ORS 442.470, or
20 rural critical access hospitals, as defined in ORS 442.470.

21 **SECTION 31.** ORS 442.396 is amended to read:

22 442.396. An insurer, as defined in ORS 731.106, that contracts with the [*Oregon Health*
23 *Authority*] **Office of Health Care Affordability**, including with the Public Employees' Benefit Board
24 and the Oregon Educators Benefit Board, to provide health insurance coverage for state employees,
25 educators or medical assistance recipients must annually attest, on a form and in a manner pre-
26 scribed by the [*authority*] **office**, to its compliance with ORS 243.256, 243.879, 442.392 and 442.394.
27 A contract with an insurer subject to the requirements of this section may not be renewed without
28 the attestation required by this section.

29 **SECTION 32.** ORS 442.993 is amended to read:

30 442.993. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** shall adopt a
31 schedule of civil penalties not to exceed \$500 per day of violation, determined by the severity of the
32 violation, for:

33 (a) Any reporting entity that fails to report as required by ORS 442.373 or rules adopted by the
34 [*authority*] **office**.

35 (b) Any provider or payer that fails to report cost growth data or to develop and implement a
36 performance improvement plan if required by ORS 442.386 or rules adopted by the [*authority*]
37 **office**.

38 (2) Civil penalties under this section shall be imposed as provided in ORS 183.745.

39 (3) Civil penalties imposed under this section may be remitted or mitigated upon such terms and
40 conditions as the [*authority*] **office** considers proper and consistent with the public health and safety.

41 (4) Civil penalties incurred under any law of this state are not allowable as costs for the purpose
42 of rate determination or for reimbursement by a third-party payer.

43 (5) Moneys collected from providers and payers described in subsection (1)(b) of this section
44 shall be deposited in the [*Oregon Health Authority Fund*] **Health Care Affordability Fund** estab-
45 lished by [*ORS 413.101*] **section 3 of this 2023 Act** and used by the [*authority*] **office** to support

1 programs that expand access to health care and that support populations adversely affected by high
 2 health care costs.

3
 4 **(Cost Reporting by Health Care Facilities)**

5
 6 **SECTION 33.** ORS 442.420 is amended to read:

7 442.420. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** may apply for,
 8 receive and accept grants, gifts, payments and other funds and advances, appropriations, properties
 9 and services from the United States, the State of Oregon or any governmental body, agency or
 10 agencies or from any other public or private corporation or person, and enter into agreements with
 11 respect thereto, including the undertaking of studies, plans, demonstrations or projects.

12 (2) The [*authority*] **office** shall conduct or cause to have conducted such analyses and studies
 13 relating to costs of health care facilities as considered desirable, including but not limited to meth-
 14 ods of reducing such costs, utilization review of services of health care facilities, peer review,
 15 quality control, financial status of any facility subject to ORS 442.400 to 442.463 and sources of
 16 public and private financing of financial requirements of such facilities.

17 (3) The [*authority*] **office** may also:

18 (a) Hold public hearings, conduct investigations and require the filing of information relating to
 19 any matter affecting the costs of and charges for services in all health care facilities;

20 (b) Subpoena witnesses, papers, records and documents the [*authority*] **office** considers material
 21 or relevant in connection with functions of the [*authority*] **office** subject to the provisions of ORS
 22 chapter 183;

23 (c) Exercise, subject to the limitations and restrictions imposed by ORS 442.400 to 442.463, all
 24 other powers which are reasonably necessary or essential to carry out the express objectives and
 25 purposes of ORS 442.400 to 442.463; and

26 (d) Adopt rules in accordance with ORS chapter 183 for carrying out the functions of the [*au-*
 27 *thority*] **office**.

28 **SECTION 34.** ORS 442.425 is amended to read:

29 442.425. (1) The [*Oregon Health Authority*] **Office of Health Care Affordability** by rule may
 30 specify one or more uniform systems of financial reporting necessary to meet the requirements of
 31 ORS 442.400 to 442.463. Such systems shall include such cost allocation methods as may be pre-
 32 scribed and such records and reports of revenues, expenses, other income and other outlays, assets
 33 and liabilities, and units of service as may be prescribed. Each facility under the [*authority's*]
 34 **Oregon Health Authority's** jurisdiction shall adopt such systems for its fiscal period starting on
 35 or after the effective date of such system and shall make the required reports on such forms as may
 36 be required by the [*authority*] **office**. The [*authority*] **office** may extend the period by which compli-
 37 ance is required upon timely application and for good cause. Filings of such records and reports
 38 shall be made at such times as may be reasonably required by the [*authority*] **office**.

39 (2) Existing systems of reporting used by health care facilities shall be given due consideration
 40 by the [*authority*] **office** in carrying out the duty of specifying the systems of reporting required by
 41 ORS 442.400 to 442.463. The [*authority*] **office** insofar as reasonably possible shall adopt reporting
 42 systems and requirements that will not unreasonably increase the administrative costs of the facil-
 43 ity.

44 (3) The [*authority*] **office** may allow and provide for modifications in the reporting systems in
 45 order to correctly reflect differences in the scope or type of services and financial structure between

1 the various categories, sizes or types of health care facilities and in a manner consistent with the
2 purposes of ORS 442.400 to 442.463.

3 (4) The [authority] **office** may establish specific annual reporting provisions for facilities that
4 receive a preponderance of their revenue from associated comprehensive group-practice prepayment
5 health care service plans. Notwithstanding any other provisions of ORS 442.400 to 442.463, such fa-
6 cilities shall be authorized to utilize established accounting systems and to report costs and reven-
7 ues in a manner consistent with the operating principles of such plans and with generally accepted
8 accounting principles. When such facilities are operated as units of a coordinated group of health
9 facilities under common ownership, the facilities shall be authorized to report as a group rather than
10 as individual institutions, and as a group shall submit a consolidated balance sheet, income and ex-
11 pense statement and statement of source and application of funds for such group of health facilities.

12 **SECTION 35.** ORS 442.430 is amended to read:

13 442.430. (1) Whenever a further investigation is considered necessary or desirable by the [*Oregon*
14 *Health Authority*] **Office of Health Care Affordability** to verify the accuracy of the information in
15 the reports made by health care facilities, the [authority] **office** may make any necessary further
16 examination of the facility's records and accounts. Such further examinations include, but are not
17 limited to, requiring a full or partial audit of all such records and accounts.

18 (2) In carrying out the duties prescribed by ORS 442.400 to 442.463, the [authority] **office** may
19 utilize its own staff or may contract with any appropriate, independent, qualified third party. No
20 such contractor shall release or publish or otherwise use any information made available to it under
21 its contractual responsibility unless such permission is specifically granted by the [authority]
22 **office**.

23 **SECTION 36.** ORS 442.460 is amended to read:

24 442.460. In order to obtain regional or statewide data about the utilization and cost of health
25 care services, the [*Oregon Health Authority*] **Office of Health Care Affordability** may accept in-
26 formation relating to the utilization and cost of health care services identified by the [authority]
27 **office** from physicians, insurers or other third-party payers or employers or other purchasers of
28 health care.

29 **SECTION 37.** ORS 442.463 is amended to read:

30 442.463. (1) Each licensed health facility shall file with the [*Oregon Health Authority*] **Office of**
31 **Health Care Affordability** an annual report containing such information related to the facility's
32 utilization as may be required by the [authority] **office**, in such form as the [authority] **office** pre-
33 scribes by rule.

34 (2) The annual report shall contain such information as may be required by rule of the
35 [authority] **office** and must be approved by the [authority] **office**.

36 **SECTION 38.** ORS 442.994 is amended to read:

37 442.994. (1) Any health care facility that fails to perform as required in ORS 442.602 [*and 442.400*
38 *to 442.463*] or 442.855, and rules of the Oregon Health Authority may be subject to a civil penalty.

39 (2) The Oregon Health Authority shall adopt a schedule of penalties not to exceed \$500 per day
40 of violation, determined by the severity of the violation.

41 (3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

42 (4) Civil penalties imposed under this section may be remitted or mitigated upon such terms and
43 conditions as the authority considers proper and consistent with the public health and safety.

44 (5) Civil penalties incurred under any law of this state are not allowable as costs for the purpose
45 of rate determination or for reimbursement by a third-party payer.

1 **SECTION 39.** (1) Any health care facility that fails to perform as required in ORS 442.400
 2 to 442.463 and rules of the Office of Health Care Affordability may be subject to a civil pen-
 3 alty.

4 (2) The office shall adopt a schedule of penalties not to exceed \$500 per day of violation,
 5 determined by the severity of the violation.

6 (3) Civil penalties under this section shall be imposed as provided in ORS 183.745.

7 (4) Civil penalties imposed under this section may be remitted or mitigated upon such
 8 terms and conditions as the office considers proper and consistent with the public health and
 9 safety.

10 (5) Civil penalties incurred under any law of this state are not allowable as costs for the
 11 purpose of rate determination or for reimbursement by a third-party payer.

12
 13 **(Primary Care Payment Reform Collaborative)**
 14

15 **SECTION 40.** Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chapter 384,
 16 Oregon Laws 2017 and section 13, chapter 489, Oregon Laws 2017, is amended to read:

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

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

19 (b) “Coordinated care organization” has the meaning given that term in ORS 414.025.

20 (c) “Primary care” means family medicine, general internal medicine, naturopathic medicine,
 21 obstetrics and gynecology, pediatrics or general psychiatry.

22 (d) “Primary care provider” includes:

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

25 (B) A health care team or clinic that has been certified by the [*Oregon Health Authority*] **Office**
 26 **of Health Care Affordability** as a patient centered primary care home.

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

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

31 (i) Increase the investment in primary care;

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

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

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

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

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

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

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

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

43 (3) The [*authority*] **office** shall invite representatives from all of the following to participate in
 44 the primary care payment reform collaborative:

45 (a) Primary care providers;

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

16 (4) The primary care payment reform collaborative shall annually report to the Oregon Health
 17 Policy Board and to the Legislative Assembly on the achievement of the primary care spending
 18 targets in ORS [414.625] **414.572** and 743.010 and the implementation of the Primary Care Transfor-
 19 mation Initiative.

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

23 (6) The [authority] **office**, in collaboration with the Department of Consumer and Business Ser-
 24 vices, shall adopt rules prescribing the primary care services for which costs must be reported under
 25 subsection (5) of this section.

26 **SECTION 41.** Section 3, chapter 575, Oregon Laws 2015, as amended by section 7, chapter 26,
 27 Oregon Laws 2016, is amended to read:

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

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

34 (2) How carriers, coordinated care organizations, the Public Employees’ Benefit Board and the
 35 Oregon Educators Benefit Board pay for primary care.

36 **SECTION 42.** Section 4, chapter 575, Oregon Laws 2015, is amended to read:

37 **Sec. 4.** (1) The Legislative Assembly declares that collaboration among insurers, purchasers and
 38 providers of health care to coordinate service delivery systems and develop innovative reimburse-
 39 ment methods in support of integrated and coordinated health care delivery is in the best interest
 40 of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust
 41 laws, and to provide immunity from federal antitrust laws through the state action doctrine, the
 42 activities specified in section 2 (2) [of this 2015 Act], **chapter 575, Oregon Laws 2015**, of the par-
 43 ticipants in the primary care payment reform collaborative, that might otherwise be constrained by
 44 such laws.

45 (2) The Director of the [Oregon Health Authority] **Office of Health Care Affordability** or the

1 director’s designee shall engage in state supervision of the primary care payment reform
 2 collaborative to ensure that the activities and discussions of the participants in the collaborative
 3 are limited to the activities described in section 2 (2) [of this 2015 Act], **chapter 575, Oregon Laws**
 4 **2015.**

5 (3) Groups that include, but are not limited to, health insurance companies, health care centers,
 6 hospitals, health service organizations, employers, health care providers, health care facilities, state
 7 and local governmental entities and consumers may meet to facilitate the development, implemen-
 8 tation and operation of the Primary Care Transformation Initiative in accordance with section 2
 9 [of this 2015 Act], **chapter 575, Oregon Laws 2015.**

10 (4) The [Oregon Health Authority] **Office of Health Care Affordability** may conduct a survey
 11 of the entities and individuals specified in subsection (3) of this section to assist in the evaluation
 12 of the Primary Care Transformation Initiative.

13 (5) A survey or meeting under subsection (3) or (4) of this section is not a violation of state
 14 antitrust laws and shall be considered state action for purposes of federal antitrust laws through the
 15 state action doctrine.

16
 17 **CONFORMING AMENDMENTS**
 18

19 **SECTION 43.** ORS 413.032, as amended by section 3, chapter 87, Oregon Laws 2022, is amended
 20 to read:

21 413.032. (1) The Oregon Health Authority is established. The authority shall:

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

23 (b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established
 24 in ORS 414.570, the COFA Premium Assistance Program established in ORS 413.610 and the COFA
 25 Dental Program established in section 1, chapter 87, Oregon Laws 2022;

26 (c) Administer the Oregon Prescription Drug Program;

27 (d) Develop the policies for and the provision of publicly funded medical care and medical as-
 28 sistance in this state;

29 (e) Develop the policies for and the provision of mental health treatment and treatment of ad-
 30 dictions;

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

32 (g) Provide regular reports to the board with respect to the performance of health services
 33 contractors serving recipients of medical assistance, including reports of trends in health services
 34 and enrollee satisfaction;

35 (h) Guide and support, with the authorization of the board, community-centered health initiatives
 36 designed to address critical risk factors, especially those that contribute to chronic disease;

37 (i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the
 38 Social Security Act and administer medical assistance under ORS chapter 414;

39 (j) In consultation with the Director of the Department of Consumer and Business Services, pe-
 40 riodically review and recommend standards and methodologies to the Legislative Assembly for:

41 (A) Review of administrative expenses of health insurers;

42 (B) Approval of rates; and

43 (C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

44 (k) Structure reimbursement rates for providers that serve recipients of medical assistance to
 45 reward comprehensive management of diseases, quality outcomes and the efficient use of resources

1 and to promote cost-effective procedures, services and programs including, without limitation, pre-
 2 ventive health, dental and primary care services, web-based office visits, telephone consultations and
 3 telemedicine consultations;

4 (L) Guide and support community three-share agreements in which an employer, state or local
 5 government and an individual all contribute a portion of a premium for a community-centered health
 6 initiative or for insurance coverage;

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

9 (n) Implement policies and programs to expand the skilled, diverse workforce as described in
 10 ORS 414.018 (4)[; *and*].

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

14 (2) The Oregon Health Authority is authorized to:

15 (a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate
 16 health care reform in Oregon and to provide comparative cost and quality information to consumers,
 17 providers and purchasers of health care about Oregon's health care systems and health plan net-
 18 works in order to provide comparative information to consumers.

19 (b) Develop uniform contracting standards for the purchase of health care, including the fol-
 20 lowing:

21 (A) Uniform quality standards and performance measures;

22 (B) Evidence-based guidelines for major chronic disease management and health care services
 23 with unexplained variations in frequency or cost;

24 (C) Evidence-based effectiveness guidelines for select new technologies and medical equipment;

25 (D) A statewide drug formulary that may be used by publicly funded health benefit plans; and

26 (E) Standards that accept and consider tribal-based practices for mental health and substance
 27 abuse prevention, counseling and treatment for persons who are Native American or Alaska Native
 28 as equivalent to evidence-based practices.

29 (3) The enumeration of duties, functions and powers in this section is not intended to be exclu-
 30 sive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Au-
 31 thority by ORS 413.006 to 413.042, 413.610 to 413.613, 415.012 to 415.430, [415.501,] 741.001 to 741.540,
 32 741.802 and 741.900 or by other statutes.

33 **SECTION 44.** ORS 413.037 is amended to read:

34 413.037. (1) The Director of the Oregon Health Authority, each deputy director and authorized
 35 representatives of the director may administer oaths, take depositions and issue subpoenas to compel
 36 the attendance of witnesses and the production of documents or other written information necessary
 37 to carry out the provisions of ORS 413.006 to 413.042, 415.012 to 415.430[415.501] and 741.340.

38 (2) If any person fails to comply with a subpoena issued under this section or refuses to testify
 39 on matters on which the person lawfully may be interrogated, the director, deputy director or au-
 40 thorized representative may follow the procedure set out in ORS 183.440 to compel obedience.

41 **SECTION 45.** ORS 413.101 is amended to read:

42 413.101. (1) The Oregon Health Authority Fund is established in the State Treasury, separate
 43 and distinct from the General Fund. Interest earned by the Oregon Health Authority Fund shall be
 44 credited to the fund.

45 (2) Except as provided in subsection (3) of this section, moneys in the fund are continuously

1 appropriated to the Oregon Health Authority for carrying out the duties, functions and powers of
2 the authority under ORS 413.032[, 415.501] and 431A.183.

3 (3)(a) Moneys deposited in the fund pursuant to ORS 431A.880 are continuously appropriated to
4 the authority for the purpose of carrying out ORS 431A.855 to 431A.900.

5 (b) The authority may accept grants, donations, gifts or moneys from any source for the pur-
6 poses of carrying out ORS 431A.855 to 431A.900. Moneys received under this paragraph shall be
7 deposited into the fund and are continuously appropriated for the purposes of carrying out ORS
8 431A.855 to 431A.900.

9 (c) Moneys subject to a federal restriction or other funding source restriction must be accounted
10 for separately from other moneys described in this subsection.

11 **SECTION 46.** ORS 413.181 is amended to read:

12 413.181. (1) The Department of Consumer and Business Services and the Oregon Health Au-
13 thority may enter into agreements governing the disclosure of information reported to the depart-
14 ment by insurers with certificates of authority to transact insurance in this state and the disclosure
15 of information reported to the Oregon Health Authority by coordinated care organizations.

16 (2) The authority may use information disclosed under subsection (1) of this section for the
17 purpose of carrying out ORS 413.032, 414.572, 414.591, 414.605, 414.609, 414.638[,] **and** 415.012 to
18 415.430 [*and 415.501*].

19 **SECTION 47.** ORS 414.025 is amended to read:

20 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially
21 applicable statutory definition requires otherwise:

22 (1)(a) “Alternative payment methodology” means a payment other than a fee-for-services pay-
23 ment, used by coordinated care organizations as compensation for the provision of integrated and
24 coordinated health care and services.

25 (b) “Alternative payment methodology” includes, but is not limited to:

26 (A) Shared savings arrangements;

27 (B) Bundled payments; and

28 (C) Payments based on episodes.

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

31 (3) “Behavioral health clinician” means:

32 (a) A licensed psychiatrist;

33 (b) A licensed psychologist;

34 (c) A licensed nurse practitioner with a specialty in psychiatric mental health;

35 (d) A licensed clinical social worker;

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

37 (f) A certified clinical social work associate;

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

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

42 (4) “Behavioral health crisis” means a disruption in an individual’s mental or emotional stability
43 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
44 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or
45 physical health.

1 (5) “Behavioral health home” means a mental health disorder or substance use disorder treat-
 2 ment organization, as defined by the [*Oregon Health Authority*] **Office of Health Care Affordability**
 3 by rule, that provides integrated health care to individuals whose primary diagnoses are mental
 4 health disorders or substance use disorders.

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

8 (7) “Community health worker” means an individual who meets qualification criteria adopted
 9 by the authority under ORS 414.665 and who:

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

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

13 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
 14 ences with the residents of the community the worker serves;

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

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

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

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

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

22 (8) “Coordinated care organization” means an organization meeting criteria adopted by the
 23 Oregon Health Authority under ORS 414.572.

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

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

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

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

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

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

35 (b) A “family support specialist” may be a peer wellness specialist or a peer support specialist.

36 (11) “Global budget” means a total amount established prospectively by the Oregon Health Au-
 37 thority to be paid to a coordinated care organization for the delivery of, management of, access to
 38 and quality of the health care delivered to members of the coordinated care organization.

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

41 (13) “Health services” means at least so much of each of the following as are funded by the
 42 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-
 43 dence Review Commission under ORS 414.690:

44 (a) Services required by federal law to be included in the state’s medical assistance program in
 45 order for the program to qualify for federal funds;

1 (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed
 2 under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of
 3 the practitioner’s practice as defined by state law, and ambulance services;

4 (c) Prescription drugs;

5 (d) Laboratory and X-ray services;

6 (e) Medical equipment and supplies;

7 (f) Mental health services;

8 (g) Chemical dependency services;

9 (h) Emergency dental services;

10 (i) Nonemergency dental services;

11 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of
 12 this subsection, defined by federal law that may be included in the state’s medical assistance pro-
 13 gram;

14 (k) Emergency hospital services;

15 (L) Outpatient hospital services; and

16 (m) Inpatient hospital services.

17 (14) “Income” has the meaning given that term in ORS 411.704.

18 (15)(a) “Integrated health care” means care provided to individuals and their families in a pa-
 19 tient centered primary care home or behavioral health home by licensed primary care clinicians,
 20 behavioral health clinicians and other care team members, working together to address one or more
 21 of the following:

22 (A) Mental illness.

23 (B) Substance use disorders.

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

25 (D) Life stressors and crises.

26 (E) Developmental risks and conditions.

27 (F) Stress-related physical symptoms.

28 (G) Preventive care.

29 (H) Ineffective patterns of health care utilization.

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

31 (A) Qualified mental health professionals or qualified mental health associates meeting require-
 32 ments adopted by the Oregon Health Authority by rule;

33 (B) Peer wellness specialists;

34 (C) Peer support specialists;

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

36 (E) Personal health navigators; or

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

38 (16) “Investments and savings” means cash, securities as defined in ORS 59.015, negotiable in-
 39 struments as defined in ORS 73.0104 and such similar investments or savings as the department or
 40 the authority may establish by rule that are available to the applicant or recipient to contribute
 41 toward meeting the needs of the applicant or recipient.

42 (17) “Medical assistance” means so much of the medical, mental health, preventive, supportive,
 43 palliative and remedial care and services as may be prescribed by the authority according to the
 44 standards established pursuant to ORS 414.065, including premium assistance under ORS 413.610 to
 45 413.613, 414.115 and 414.117, payments made for services provided under an insurance or other

1 contractual arrangement and money paid directly to the recipient for the purchase of health services
 2 and for services described in ORS 414.710.

3 (18) “Medical assistance” includes any care or services for any individual who is a patient in
 4 a medical institution or any care or services for any individual who has attained 65 years of age
 5 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-
 6 eases. Except as provided in ORS 411.439 and 411.447, “medical assistance” does not include care
 7 or services for a resident of a nonmedical public institution.

8 (19) “Patient centered primary care home” means a health care team or clinic that is organized
 9 in accordance with the standards established by the [*Oregon Health Authority*] **Office of Health**
 10 **Care Affordability** under ORS 414.655 and that incorporates the following core attributes:

- 11 (a) Access to care;
- 12 (b) Accountability to consumers and to the community;
- 13 (c) Comprehensive whole person care;
- 14 (d) Continuity of care;
- 15 (e) Coordination and integration of care; and
- 16 (f) Person and family centered care.

17 (20) “Peer support specialist” means any of the following individuals who meet qualification
 18 criteria adopted by the authority under ORS 414.665 and who provide supportive services to a cur-
 19 rent or former consumer of mental health or addiction treatment:

- 20 (a) An individual who is a current or former consumer of mental health treatment; or
- 21 (b) An individual who is in recovery, as defined by the Oregon Health Authority by rule, from
 22 an addiction disorder.

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

31 (22) “Person centered care” means care that:

- 32 (a) Reflects the individual patient’s strengths and preferences;
- 33 (b) Reflects the clinical needs of the patient as identified through an individualized assessment;
 34 and
- 35 (c) Is based upon the patient’s goals and will assist the patient in achieving the goals.

36 (23) “Personal health navigator” means an individual who meets qualification criteria adopted
 37 by the authority under ORS 414.665 and who provides information, assistance, tools and support to
 38 enable a patient to make the best health care decisions in the patient’s particular circumstances and
 39 in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes.

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

44 (25) “Quality measure” means the health outcome and quality measures and benchmarks identi-
 45 fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in

1 accordance with ORS 413.017 (4) and 414.638 and the quality metrics developed by the Behavioral
 2 Health Committee in accordance with ORS 413.017 (5).

3 (26) “Resources” has the meaning given that term in ORS 411.704. For eligibility purposes, “re-
 4 sources” does not include charitable contributions raised by a community to assist with medical
 5 expenses.

6 (27) “Tribal traditional health worker” means an individual who meets qualification criteria
 7 adopted by the authority under ORS 414.665 and who:

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

9 (b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer
 10 in association with a local health care system;

11 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
 12 ences with the residents of the community the worker serves;

13 (d) Assists members of the community to improve their health, including physical, behavioral and
 14 oral health, and increases the capacity of the community to meet the health care needs of its resi-
 15 dents and achieve wellness;

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

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

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

20 (h) May provide direct services, such as tribal-based practices.

21 (28)(a) “Youth support specialist” means an individual who meets qualification criteria adopted
 22 by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive
 23 services to an individual who:

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

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

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

28 (b) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

29 **SECTION 48.** ORS 414.025, as amended by section 2, chapter 628, Oregon Laws 2021, is
 30 amended to read:

31 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially
 32 applicable statutory definition requires otherwise:

33 (1)(a) “Alternative payment methodology” means a payment other than a fee-for-services pay-
 34 ment, used by coordinated care organizations as compensation for the provision of integrated and
 35 coordinated health care and services.

36 (b) “Alternative payment methodology” includes, but is not limited to:

37 (A) Shared savings arrangements;

38 (B) Bundled payments; and

39 (C) Payments based on episodes.

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

42 (3) “Behavioral health clinician” means:

43 (a) A licensed psychiatrist;

44 (b) A licensed psychologist;

45 (c) A licensed nurse practitioner with a specialty in psychiatric mental health;

- 1 (d) A licensed clinical social worker;
- 2 (e) A licensed professional counselor or licensed marriage and family therapist;
- 3 (f) A certified clinical social work associate;
- 4 (g) An intern or resident who is working under a board-approved supervisory contract in a
5 clinical mental health field; or
- 6 (h) Any other clinician whose authorized scope of practice includes mental health diagnosis and
7 treatment.
- 8 (4) “Behavioral health crisis” means a disruption in an individual’s mental or emotional stability
9 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
10 partment or admission to a hospital to prevent a serious deterioration in the individual’s mental or
11 physical health.
- 12 (5) “Behavioral health home” means a mental health disorder or substance use disorder treat-
13 ment organization, as defined by the [*Oregon Health Authority*] **Office of Health Care Affordability**
14 by rule, that provides integrated health care to individuals whose primary diagnoses are mental
15 health disorders or substance use disorders.
- 16 (6) “Category of aid” means assistance provided by the Oregon Supplemental Income Program,
17 aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Supplemental Security
18 Income payments.
- 19 (7) “Community health worker” means an individual who meets qualification criteria adopted
20 by the authority under ORS 414.665 and who:
- 21 (a) Has expertise or experience in public health;
- 22 (b) Works in an urban or rural community, either for pay or as a volunteer in association with
23 a local health care system;
- 24 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
25 ences with the residents of the community the worker serves;
- 26 (d) Assists members of the community to improve their health and increases the capacity of the
27 community to meet the health care needs of its residents and achieve wellness;
- 28 (e) Provides health education and information that is culturally appropriate to the individuals
29 being served;
- 30 (f) Assists community residents in receiving the care they need;
- 31 (g) May give peer counseling and guidance on health behaviors; and
- 32 (h) May provide direct services such as first aid or blood pressure screening.
- 33 (8) “Coordinated care organization” means an organization meeting criteria adopted by the
34 Oregon Health Authority under ORS 414.572.
- 35 (9) “Dually eligible for Medicare and Medicaid” means, with respect to eligibility for enrollment
36 in a coordinated care organization, that an individual is eligible for health services funded by Title
37 XIX of the Social Security Act and is:
- 38 (a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or
- 39 (b) Enrolled in Part B of Title XVIII of the Social Security Act.
- 40 (10)(a) “Family support specialist” means an individual who meets qualification criteria adopted
41 by the authority under ORS 414.665 and who provides supportive services to and has experience
42 parenting a child who:
- 43 (A) Is a current or former consumer of mental health or addiction treatment; or
- 44 (B) Is facing or has faced difficulties in accessing education, health and wellness services due
45 to a mental health or behavioral health barrier.

1 (b) A “family support specialist” may be a peer wellness specialist or a peer support specialist.

2 (11) “Global budget” means a total amount established prospectively by the Oregon Health Au-
 3 thority to be paid to a coordinated care organization for the delivery of, management of, access to
 4 and quality of the health care delivered to members of the coordinated care organization.

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

7 (13) “Health services” means at least so much of each of the following as are funded by the
 8 Legislative Assembly based upon the prioritized list of health services compiled by the Health Evi-
 9 dence Review Commission under ORS 414.690:

10 (a) Services required by federal law to be included in the state’s medical assistance program in
 11 order for the program to qualify for federal funds;

12 (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner licensed
 13 under ORS 678.375, a behavioral health clinician or other licensed practitioner within the scope of
 14 the practitioner’s practice as defined by state law, and ambulance services;

15 (c) Prescription drugs;

16 (d) Laboratory and X-ray services;

17 (e) Medical equipment and supplies;

18 (f) Mental health services;

19 (g) Chemical dependency services;

20 (h) Emergency dental services;

21 (i) Nonemergency dental services;

22 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of
 23 this subsection, defined by federal law that may be included in the state’s medical assistance pro-
 24 gram;

25 (k) Emergency hospital services;

26 (L) Outpatient hospital services; and

27 (m) Inpatient hospital services.

28 (14) “Income” has the meaning given that term in ORS 411.704.

29 (15)(a) “Integrated health care” means care provided to individuals and their families in a pa-
 30 tient centered primary care home or behavioral health home by licensed primary care clinicians,
 31 behavioral health clinicians and other care team members, working together to address one or more
 32 of the following:

33 (A) Mental illness.

34 (B) Substance use disorders.

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

36 (D) Life stressors and crises.

37 (E) Developmental risks and conditions.

38 (F) Stress-related physical symptoms.

39 (G) Preventive care.

40 (H) Ineffective patterns of health care utilization.

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

42 (A) Qualified mental health professionals or qualified mental health associates meeting require-
 43 ments adopted by the Oregon Health Authority by rule;

44 (B) Peer wellness specialists;

45 (C) Peer support specialists;

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

2 (E) Personal health navigators; or

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

4 (16) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable in-
5 struments as defined in ORS 73.0104 and such similar investments or savings as the department or
6 the authority may establish by rule that are available to the applicant or recipient to contribute
7 toward meeting the needs of the applicant or recipient.

8 (17) "Medical assistance" means so much of the medical, mental health, preventive, supportive,
9 palliative and remedial care and services as may be prescribed by the authority according to the
10 standards established pursuant to ORS 414.065, including premium assistance under ORS 413.610 to
11 413.613, 414.115 and 414.117, payments made for services provided under an insurance or other
12 contractual arrangement and money paid directly to the recipient for the purchase of health services
13 and for services described in ORS 414.710.

14 (18) "Medical assistance" includes any care or services for any individual who is a patient in
15 a medical institution or any care or services for any individual who has attained 65 years of age
16 or is under 22 years of age, and who is a patient in a private or public institution for mental dis-
17 eases. Except as provided in ORS 411.439 and 411.447, "medical assistance" does not include care
18 or services for a resident of a nonmedical public institution.

19 (19) "Mental health drug" means a type of legend drug, as defined in ORS 414.325, specified by
20 the Oregon Health Authority by rule, including but not limited to:

21 (a) Therapeutic class 7 ataractics-tranquilizers; and

22 (b) Therapeutic class 11 psychostimulants-antidepressants.

23 (20) "Patient centered primary care home" means a health care team or clinic that is organized
24 in accordance with the standards established by the [*Oregon Health Authority*] **Office of Health**
25 **Care Affordability** under ORS 414.655 and that incorporates the following core attributes:

26 (a) Access to care;

27 (b) Accountability to consumers and to the community;

28 (c) Comprehensive whole person care;

29 (d) Continuity of care;

30 (e) Coordination and integration of care; and

31 (f) Person and family centered care.

32 (21) "Peer support specialist" means any of the following individuals who meet qualification
33 criteria adopted by the authority under ORS 414.665 and who provide supportive services to a cur-
34 rent or former consumer of mental health or addiction treatment:

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

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

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

- 1 (23) “Person centered care” means care that:
 2 (a) Reflects the individual patient’s strengths and preferences;
 3 (b) Reflects the clinical needs of the patient as identified through an individualized assessment;
 4 and
 5 (c) Is based upon the patient’s goals and will assist the patient in achieving the goals.
 6 (24) “Personal health navigator” means an individual who meets qualification criteria adopted
 7 by the authority under ORS 414.665 and who provides information, assistance, tools and support to
 8 enable a patient to make the best health care decisions in the patient’s particular circumstances and
 9 in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes.
 10 (25) “Prepaid managed care health services organization” means a managed dental care, mental
 11 health or chemical dependency organization that contracts with the authority under ORS 414.654
 12 or with a coordinated care organization on a prepaid capitated basis to provide health services to
 13 medical assistance recipients.
 14 (26) “Quality measure” means the health outcome and quality measures and benchmarks identi-
 15 fied by the Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in
 16 accordance with ORS 413.017 (4) and 414.638 and the quality metrics developed by the Behavioral
 17 Health Committee in accordance with ORS 413.017 (5).
 18 (27) “Resources” has the meaning given that term in ORS 411.704. For eligibility purposes, “re-
 19 sources” does not include charitable contributions raised by a community to assist with medical
 20 expenses.
 21 (28) “Tribal traditional health worker” means an individual who meets qualification criteria
 22 adopted by the authority under ORS 414.665 and who:
 23 (a) Has expertise or experience in public health;
 24 (b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer
 25 in association with a local health care system;
 26 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experi-
 27 ences with the residents of the community the worker serves;
 28 (d) Assists members of the community to improve their health, including physical, behavioral and
 29 oral health, and increases the capacity of the community to meet the health care needs of its resi-
 30 dents and achieve wellness;
 31 (e) Provides health education and information that is culturally appropriate to the individuals
 32 being served;
 33 (f) Assists community residents in receiving the care they need;
 34 (g) May give peer counseling and guidance on health behaviors; and
 35 (h) May provide direct services, such as tribal-based practices.
 36 (29)(a) “Youth support specialist” means an individual who meets qualification criteria adopted
 37 by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive
 38 services to an individual who:
 39 (A) Is not older than 30 years of age; and
 40 (B)(i) Is a current or former consumer of mental health or addiction treatment; or
 41 (ii) Is facing or has faced difficulties in accessing education, health and wellness services due
 42 to a mental health or behavioral health barrier.
 43 (b) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.
 44 **SECTION 49.** ORS 414.591 is amended to read:
 45 414.591. (1) The Oregon Health Authority shall use, to the greatest extent possible, coordinated

1 care organizations to provide fully integrated physical health services, chemical dependency and
2 mental health services and oral health services. This section, and any contract entered into pur-
3 suant to this section, does not affect and may not alter the delivery of Medicaid-funded long term
4 care services.

5 (2) The authority shall execute contracts with coordinated care organizations that meet the
6 criteria adopted by the authority under ORS 414.572. Contracts under this subsection are not subject
7 to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235.

8 (3)(a) The authority shall establish financial reporting requirements for coordinated care organ-
9 izations, consistent with ORS 415.115 and 731.574, no less than 90 days before the beginning of the
10 reporting period. The authority shall prescribe requirements and procedures for financial reporting
11 that:

12 (A) Enable the authority to verify that the coordinated care organization's capital, surplus, re-
13 serves and other financial resources are adequate to ensure against the risk of insolvency;

14 (B) Include information on the three highest executive salary and benefit packages of each co-
15 ordinated care organization;

16 (C) Require quarterly reports to be filed with the authority by May 31, August 31 and November
17 30;

18 (D) In addition to the annual audited financial statement required by ORS 415.115, require an
19 annual report to be filed with the authority by April 30 following the end of the period for which
20 data is reported; and

21 (E) Align, to the greatest extent practicable, with the National Association of Insurance
22 Commissioners' reporting forms to reduce the administrative costs of coordinated care organizations
23 that are also regulated by the Department of Consumer and Business Services or have affiliates that
24 are regulated by the department.

25 (b) The authority shall provide information to coordinated care organizations about the report-
26 ing standards of the National Association of Insurance Commissioners and provide training on the
27 reporting standards to the staff of coordinated care organizations who will be responsible for com-
28 piling the reports.

29 (4) The authority shall hold coordinated care organizations, contractors and providers account-
30 able for timely submission of outcome and quality data, including but not limited to data described
31 in ORS 442.373, prescribed by the [authority] **Office of Health Care Affordability** by rule.

32 (5) The authority shall require compliance with the provisions of subsections (3) and (4) of this
33 section as a condition of entering into a contract with a coordinated care organization. A coordi-
34 nated care organization, contractor or provider that fails to comply with subsection (3) or (4) of this
35 section may be subject to sanctions, including but not limited to civil penalties, barring any new
36 enrollment in the coordinated care organization and termination of the contract.

37 (6)(a) The authority shall adopt rules and procedures to ensure that if a rural health clinic
38 provides a health service to a member of a coordinated care organization, and the rural health clinic
39 is not participating in the member's coordinated care organization, the rural health clinic receives
40 total aggregate payments from the member's coordinated care organization, other payers on the
41 claim and the authority that are no less than the amount the rural health clinic would receive in
42 the authority's fee-for-service payment system. The authority shall issue a payment to the rural
43 health clinic in accordance with this subsection within 45 days of receipt by the authority of a
44 completed billing form.

45 (b) "Rural health clinic," as used in this subsection, shall be defined by the authority by rule

1 and shall conform, as far as practicable or applicable in this state, to the definition of that term in
2 42 U.S.C. 1395x(aa)(2).

3 (7) The authority may contract with providers other than coordinated care organizations to
4 provide integrated and coordinated health care in areas that are not served by a coordinated care
5 organization or where the organization's provider network is inadequate. Contracts authorized by
6 this subsection are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290
7 and 279B.235.

8 (8) The aggregate expenditures by the authority for health services provided pursuant to this
9 chapter may not exceed the total dollars appropriated for health services under this chapter.

10 (9) Actions taken by providers, potential providers, contractors and bidders in specific accord-
11 ance with this chapter in forming consortiums or in otherwise entering into contracts to provide
12 health care services shall be performed pursuant to state supervision and shall be considered to be
13 conducted at the direction of this state, shall be considered to be lawful trade practices and may
14 not be considered to be the transaction of insurance for purposes of the Insurance Code.

15 (10) Health care providers contracting to provide services under this chapter shall advise a pa-
16 tient of any service, treatment or test that is medically necessary but not covered under the con-
17 tract if an ordinarily careful practitioner in the same or similar community would do so under the
18 same or similar circumstances.

19 (11) A coordinated care organization shall provide information to a member as prescribed by the
20 authority by rule, including but not limited to written information, within 30 days of enrollment with
21 the coordinated care organization about available providers.

22 (12) Each coordinated care organization shall work to provide assistance that is culturally and
23 linguistically appropriate to the needs of the member to access appropriate services and participate
24 in processes affecting the member's care and services.

25 (13) Each coordinated care organization shall provide upon the request of a member or pro-
26 spective member annual summaries of the organization's aggregate data regarding:

27 (a) Grievances and appeals; and

28 (b) Availability and accessibility of services provided to members.

29 (14) A coordinated care organization may not limit enrollment in a geographic area based on the
30 zip code of a member or prospective member.

31 **SECTION 50.** ORS 414.619 is amended to read:

32 414.619. (1) The Oregon Health Authority and the Department of Human Services shall cooper-
33 ate with each other by coordinating actions and responsibilities necessary to implement the Oregon
34 Integrated and Coordinated Health Care Delivery System established in ORS 414.570.

35 (2) The authority and the department may delegate to each other any duties, functions or powers
36 that the authority or department are authorized to perform if necessary to carry out this section
37 and ORS 414.572, 414.598, 414.605, 414.607, 414.632, 414.638, 414.654[, 414.655] and 414.665.

38 **SECTION 51.** ORS 415.013 is amended to read:

39 415.013. (1) The Oregon Health Authority shall enforce the provisions of ORS 415.012 to 415.430
40 [and 415.501] and rules adopted pursuant to ORS 415.011, 415.012 to 415.430 [and 415.501] for the
41 public good.

42 (2) The authority has the powers and authority expressly conferred by or reasonably implied
43 from the provisions of ORS 415.012 to 415.430 [and 415.501] and rules adopted pursuant to ORS
44 415.011, 415.012 to 415.430 [and 415.501].

45 (3) The authority may conduct examinations and investigations and require the production of

1 books, records, accounts, papers, documents and computer and other recordings the authority con-
2 siderers necessary to administer and enforce ORS 415.012 to 415.430 [or 415.501] and any rules adopted
3 pursuant to ORS 415.011, 415.012 to 415.430 [or 415.501].

4 **SECTION 52.** ORS 415.019 is amended to read:

5 415.019. (1) The Oregon Health Authority shall hold a contested case hearing upon written re-
6 quest for a hearing by a person aggrieved by any act, threatened act or failure of the authority to
7 act under ORS 415.012 to 415.430 [or 415.501] or rules adopted pursuant to ORS 415.011[,] **or** 415.012
8 to 415.430 [or 415.501].

9 (2) The provisions of ORS chapter 183 govern the hearing procedures and any judicial review
10 of a final order issued in a contested case hearing.

11 **SECTION 53.** ORS 415.103 is amended to read:

12 415.103. A person may not file or cause to be filed with the Oregon Health Authority any article,
13 certificate, report, statement, application or other information required or permitted to be filed un-
14 der ORS 415.012 to 415.430 [or 415.501] or rules adopted pursuant to ORS 415.011[,] **or** 415.012 to
15 415.430 [or 415.501] that is known by the person to be false or misleading in any material respect.

16 **SECTION 54.** ORS 646A.694 is amended to read:

17 646A.694. (1) The Department of Consumer and Business Services shall provide to the Pre-
18 scription Drug Affordability Board each calendar quarter a list of prescription drugs included in
19 reports submitted to the department under ORS 646A.689 (2) and (6), a list of drugs included in re-
20 ports submitted to the department under ORS 743.025 and a list of insulin drugs marketed in this
21 state during the previous calendar year. Each calendar year, the board shall identify nine drugs and
22 at least one insulin product from the lists provided under this subsection that the board determines
23 may create affordability challenges for health care systems or high out-of-pocket costs for patients
24 in this state based on criteria adopted by the board by rule, including but not limited to:

25 (a) Whether the prescription drug has led to health inequities in communities of color;

26 (b) The number of residents in this state prescribed the prescription drug;

27 (c) The price for the prescription drug sold in this state;

28 (d) The estimated average monetary price concession, discount or rebate the manufacturer pro-
29 vides to health insurance plans in this state or is expected to provide to health insurance plans in
30 this state, expressed as a percentage of the price for the prescription drug under review;

31 (e) The estimated total amount of the price concession, discount or rebate the manufacturer
32 provides to each pharmacy benefit manager registered in this state for the prescription drug under
33 review, expressed as a percentage of the prices;

34 (f) The estimated price for therapeutic alternatives to the drug that are sold in this state;

35 (g) The estimated average price concession, discount or rebate the manufacturer provides or is
36 expected to provide to health insurance plans and pharmacy benefit managers in this state for
37 therapeutic alternatives;

38 (h) The estimated costs to health insurance plans based on patient use of the drug consistent
39 with the labeling approved by the United States Food and Drug Administration and recognized
40 standard medical practice;

41 (i) The impact on patient access to the drug considering standard prescription drug benefit de-
42 signs in health insurance plans offered in this state;

43 (j) The relative financial impacts to health, medical or social services costs as can be quantified
44 and compared to the costs of existing therapeutic alternatives;

45 (k) The estimated average patient copayment or other cost-sharing for the prescription drug in

1 this state;

2 (L) Any information a manufacturer chooses to provide; and

3 (m) Any other factors as determined by the board in rules adopted by the board.

4 (2) A drug that is designated by the Secretary of the United States Food and Drug Adminis-
5 tration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition is not subject to review
6 under subsection (1) of this section.

7 (3) The board shall accept testimony from patients and caregivers affected by a condition or
8 disease that is treated by a prescription drug under review by the board and from individuals with
9 scientific or medical training with respect to the disease or condition.

10 (4)(a) If the board considers the cost-effectiveness of a prescription drug in criteria adopted by
11 the board under subsection (1) of this section, the board may not use quality-adjusted life-years, or
12 similar formulas that take into account a patient’s age or severity of illness or disability, to identify
13 subpopulations for which a prescription drug would be less cost-effective. For any prescription drug
14 that extends life, the board’s analysis of cost-effectiveness must weigh the value of the quality of life
15 equally for all patients, regardless of the patients’ age or severity of illness or disability.

16 (b) As used in this subsection:

17 (A) “Health utility” means a measure of the degree to which having a particular form of disease
18 or disability or having particular functional limitations negatively impacts the quality of life as
19 compared to a state of perfect health, expressed as a number between zero and one.

20 (B) “Quality-adjusted life-year” is the product of a health utility multiplied by the extra months
21 or years of life that a patient might gain as a result of a treatment.

22 (5) To the extent practicable, the board shall access pricing information for prescription drugs
23 by:

24 (a) Accessing pricing information collected by the department under ORS 646A.689 and 743.025;

25 (b) Accessing data reported to the [*Oregon Health Authority*] **Office of Health Care**
26 **Affordability** under ORS 442.373;

27 (c) Entering into a memorandum of understanding with another state to which manufacturers
28 already report pricing information; and

29 (d) Accessing other publicly available pricing information.

30 (6) The information used to conduct an affordability review may include any document and re-
31 search related to the introductory price or price increase of a prescription drug, including life cycle
32 management, net average price in this state, market competition and context, projected revenue and
33 the estimated value or cost-effectiveness of the prescription drug.

34 (7) The department and the board shall keep strictly confidential any information collected, used
35 or relied upon for the review conducted under this section if the information is:

36 (a) Information submitted to the department by a manufacturer under ORS 646A.689; and

37 (b) Confidential, proprietary or a trade secret as defined in ORS 192.345.

38 **SECTION 55.** ORS 743A.078, as amended by section 1, chapter 94, Oregon Laws 2022, is
39 amended to read:

40 743A.078. (1) As used in this section, “carrier,” “enrollee” and “health benefit plan” have the
41 meanings given those terms in ORS 743B.005.

42 (2) A health benefit plan offered in this state must reimburse in full the cost to a provider of
43 delivering universal newborn nurse home visiting services, as prescribed by the [*Oregon Health*
44 *Authority*] **Office of Health Care Affordability** by rule under ORS 433.301 (7) and (8).

45 (3) The coverage must be provided without any cost-sharing, coinsurance or deductible applica-

ble to the services.

(4) Carriers must offer the services in their health benefit plans but enrollees are not required to receive the services as a condition of coverage and may not be penalized or in any way discouraged from declining the services.

(5) A carrier must notify an enrollee about the services whenever an enrollee adds a newborn to coverage.

(6) A carrier may use in-network providers or may contract with local public health authorities to provide the services.

(7) Carriers shall report to the [authority] office, in the form and manner prescribed by the [authority] office, data regarding claims submitted for services covered under this section to monitor the provision of the services.

(8) This section is exempt from ORS 743A.001.

UNIT CAPTIONS

SECTION 56. The unit captions used in this 2023 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2023 Act.

OPERATIVE DATES

SECTION 57. The transfer of duties, functions, powers, records, property, employees and moneys by sections 1 to 3 of this 2023 Act and the amendments to ORS 413.017, 413.032, 413.037, 413.101, 413.181, 413.231, 413.248, 413.259, 413.260, 414.025, 414.591, 414.619, 414.655, 415.013, 415.019, 415.103, 415.500, 415.501, 415.505, 415.510, 415.512, 415.900, 433.301, 442.315, 442.325, 442.342, 442.362, 442.370, 442.373, 442.386, 442.392, 442.394, 442.396, 442.420, 442.425, 442.430, 442.460, 442.463, 442.991, 442.993, 442.994, 646A.694 and 743A.078 and sections 2 to 4, chapter 575, Oregon Laws 2015, and section 6a, chapter 615, Oregon Laws 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this 2023 Act does not become operative until the Director of the Office of Health Care Affordability has been appointed and has qualified. Until appointment and qualification, the Oregon Health Authority and the Oregon Health Policy Board shall continue to perform the duties and functions, exercise the powers and have charge of the records, property, employees and moneys.

SECTION 58. Except as provided in section 58 of this 2023 Act, sections 1 to 3, 16, 19 and 39 of this 2023 Act and the amendments to ORS 413.017, 413.032, 413.037, 413.101, 413.181, 413.231, 413.248, 413.259, 413.260, 414.025, 414.591, 414.619, 414.655, 415.013, 415.019, 415.103, 415.500, 415.501, 415.505, 415.510, 415.512, 415.900, 433.301, 442.315, 442.325, 442.342, 442.362, 442.370, 442.373, 442.386, 442.392, 442.394, 442.396, 442.420, 442.425, 442.430, 442.460, 442.463, 442.991, 442.993, 442.994, 646A.694 and 743A.078 and sections 2 to 4, chapter 575, Oregon Laws 2015, and section 6a, chapter 615, Oregon Laws 2021, by sections 4 to 15, 17, 20 to 38 and 40 to 56 of this 2023 Act become operative on January 1, 2024.

EFFECTIVE DATE

1 **SECTION 59.** This 2023 Act takes effect on the 91st day after the date on which the 2023
2 regular session of the Eighty-second Legislative Assembly adjourns sine die.
3 _____