B-Engrossed
Senate Bill 440

Ordered by the House May 21
Including Senate Amendments dated April 16 and House Amendments
dated May 21

Sponsored by Senator STEINER HAYWARD (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires Oregon Health Policy Board to develop strategic plan for collection and use of health care data and to establish Health Plan Quality Metrics Committee**, appointed by Governor,** to develop health outcome and quality measures for coordinated care organizations and plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board and publish data. Requires Oregon Health Authority to give coordinated care organizations three months' advance notice before changing health outcome and quality measures in contract.

Makes metrics and scoring committee subcommittee of Health Plan Quality Metrics Committee.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to measuring the quality of health care; creating new provisions; amending ORS 243.135, 243.866, 413.011, 413.017, 413.032, 413.181, 414.025, 414.638, 414.679 and 417.721 and section 1, chapter 608, Oregon Laws 2013; repealing section 1, chapter 608, Oregon Laws 2013; and declaring an emergency.

Whereas key elements of this state's health system transformation efforts include reducing costs while improving quality, outcomes, public health and patients' experiences; and

Whereas health care data and performance metrics are important to track progress and create incentives for transformation in the health care system; and

Whereas performance metrics will only be effective at driving transformation through the health care system if they are evidence-based, aligned across health care programs and remain consistent long enough for the transformation efforts to take root; and

Whereas coordination across state agencies and programs is critical in achieving transformation; and

Whereas both the state and stakeholders will benefit from streamlining efforts with respect to health care data reporting and use and the establishment of performance metrics; and

Whereas creating a statewide strategic plan for health care data and performance metrics would ensure data collection and performance metrics efforts are focused on specific goals over a period of time and provide value to this state, stakeholders and consumers; and

Whereas utilizing a single body to align health care data use and performance measures will ensure efforts are coordinated, evidence-based and transformational and remain focused on a long term statewide vision; now, therefore,

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

SECTION 1. (1) The Oregon Health Policy Board, in consultation with the Public

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.

Employees' Benefit Board, the Oregon Educators Benefit Board, the Oregon Health Authority and the Department of Consumer and Business Services shall develop a statewide strategic plan for the collection and use of health care data. The plan must:

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

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

(c) Ensure that the state's efforts in the collection and use of health care data encourage integrated and coordinated care, promote improved quality, health outcomes and patient satisfaction and help reduce costs;

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

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

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

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

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

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

SECTION 2. ORS 413.017 is amended to read:

413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) [*and (3)*] **to (4)** of this section.

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

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

(C) Trustees of the Public Employees Retirement System.

(D) A city government.

(E) A county government.

(F) A special district.

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

(b) The Public Health Benefit Purchasers Committee shall:

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

(B) Develop an action plan for ongoing collaboration to implement the benefit design alignment

described in subparagraph (A) of this paragraph and shall leverage purchasing to achieve benefit uniformity if practicable.

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

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

[*(d) Proposals and plans developed in accordance with this subsection shall be completed by October 1, 2010, and shall be submitted to the Oregon Health Policy Board for its approval and possible referral to the Legislative Assembly no later than December 31, 2010.*]

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

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

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

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

(A) An individual representing the Oregon Health Authority;

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

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

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

(E) Two health care providers;

(F) One individual representing hospitals;

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

(H) Two individuals representing health care consumers;

(I) Two individuals representing coordinated care organizations;

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

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

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

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

a long term statewide vision.

(c) The committee shall use a public process that includes an opportunity for public comment to identify health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board. The Oregon Health Authority, the Department of Consumer and Business Services, the Oregon Educators Benefit Board and the Public Employees' Benefit Board are not required to adopt all of the health outcome and quality measures identified by the committee but may not adopt any health outcome and quality measures that are different from the measures identified by the committee. The measures must take into account the recommendations of the metrics and scoring subcommittee created in ORS 414.638 and the differences in the populations served by coordinated care organizations and by commercial insurers.

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

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

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

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

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

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

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

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

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

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

[*(4)*] **(5)** Members of the committees described in subsections (2) [*and (3)*] **to (4)** of this section who are not members of the Oregon Health Policy Board are not entitled to compensation but shall

be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

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

SECTION 4. ORS 243.135 is amended to read:

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

(a) Employee choice among high quality plans;

(b) A competitive marketplace;

(c) Plan performance and information;

(d) Employer flexibility in plan design and contracting;

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation; [*and*]

(h) The improvement of employee health**; and**

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

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

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

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

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

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

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

SECTION 5. ORS 243.866 is amended to read:

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

(a) Employee choice among high-quality plans;

(b) Encouragement of a competitive marketplace;

(c) Plan performance and information;

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

(e) Quality customer service;

(f) Creativity and innovation;

(g) Plan benefits as part of total employee compensation; [*and*]

(h) Improvement of employee health**; and**

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

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

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

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

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

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

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

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

SECTION 6. ORS 413.011 is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) [*Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks*] **Publish health outcome and quality measure data collected by the Oregon Health Authority at aggregate levels that do not disclose information otherwise protected by law. The information published must report, for each coordinated care organization and each health benefit plan sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board:**

(A) Quality measures;

(B) Costs;

(C) Health outcomes; and

(D) Other information that is necessary for members of the public to evaluate the value of health services delivered by each coordinated care organization and by each health benefit plan.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 (1)(h) that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the Oregon health insurance exchange.

(k) Investigate and report annually to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(C) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical

assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042 and 741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 7. ORS 413.032 is amended to read:

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

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

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

(c) Administer the Oregon Prescription Drug Program;

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

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

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

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

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

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

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

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

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

(k) Structure reimbursement rates for providers that serve recipients of medical assistance to

reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

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

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

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

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

(2) The Oregon Health Authority is authorized to:

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

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

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

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

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

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042 and 741.340 or by other statutes.

SECTION 8. ORS 413.181 is amended to read:

413.181. (1) The Department of Consumer and Business Services and the Oregon Health Authority may enter into agreements governing the disclosure of information reported to the department by insurers with certificates of authority to transact insurance in this state.

(2) The authority may use information disclosed under subsection (1) of this section for the purpose of carrying out ORS **413.032,** 414.625, 414.635, 414.638, 414.645 and 414.651.

SECTION 9. ORS 414.025 is amended to read:

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

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

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

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(3) "Community health worker" means an individual who:

(a) Has expertise or experience in public health;

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

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

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

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

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

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

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

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

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

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

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

(6) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

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

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

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

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

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

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

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

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

(11) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(12) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(13) "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

(14) "Person centered care" means care that:

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

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

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

(15) "Personal health navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

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

(17) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 10. ORS 414.638 is amended to read:

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

(a) Three members at large;

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

(c) Three representatives of coordinated care organizations.

(2) The [*committee*] **subcommittee** shall [*use a public process to identify objective outcome and quality measures, including measures of*] **select, from the health** outcome and quality [*for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health*] **measures identified by the Health Plan Quality Metrics Committee, the health outcome and quality measures applicable to** services provided by coordinated care organizations. [*Quality measures adopted by the committee must be consistent with existing state and national quality measures.*] The Oregon Health Authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. **The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.**

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

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

(b) Changes in membership of the organization;

(c) The organization's costs for implementing outcome and quality measures; and

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

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

[*(5) The authority shall utilize available data systems for reporting outcome and quality measures adopted by the committee and take actions to eliminate any redundant reporting or reporting of limited value.*]

[*(6) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:*]

[*(a) Quality measures;*]

[*(b) Costs;*]

[*(c) Outcomes; and*]

[*(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.*]

SECTION 11. ORS 414.679 is amended to read:

414.679. (1) The Oregon Health Authority shall ensure the appropriate use of member information by coordinated care organizations, including the use of electronic health information and administrative data that is available when and where the data is needed to improve health and health care through a secure, confidential health information exchange.

(2) A member of a coordinated care organization must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 so the member can share the information with others involved in the member's care and make better health care and lifestyle choices.

(3) Notwithstanding ORS 179.505, a coordinated care organization, its provider network and programs administered by the Department of Human Services for seniors and persons with disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members.

(4) A coordinated care organization and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the coordinated care organization for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the coordinated care organization and the organization's providers for purposes unrelated to this section or the requirements of ORS **413.032,** 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.

(5) This section does not prohibit the disclosure of information between a coordinated care organization and the organization's provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the laws of Oregon.

(6) The Health Information Technology Oversight Council shall develop readily available informational materials that can be used by coordinated care organizations and providers to inform all participants in the health care workforce about the appropriate uses and limitations on disclosure of electronic health records, including need-based access and privacy mandates.

SECTION 12. ORS 417.721 is amended to read:

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

SECTION 13. Section 1, chapter 608, Oregon Laws 2013, as amended by section 6, chapter 16, Oregon Laws 2015, is amended to read:

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

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

(b) "Hospital" means a hospital that is subject to the assessment imposed under section 2, chapter 736, Oregon Laws 2003.

(c) "Metrics and scoring [*committee*] **subcommittee**" means the [*committee*] **subcommittee** created in ORS 414.638.

(2) In consultation with the President of the Senate and the Speaker of the House of Representatives, the Director of the Oregon Health Authority shall appoint a hospital performance metrics advisory committee consisting of nine members, including:

(a) Four members who represent hospitals;

(b) Three members who have expertise in measuring health outcomes; and

(c) Two members who represent coordinated care organizations.

(3) The hospital performance metrics advisory committee shall recommend three to five performance standards that are consistent with state and national quality standards.

(4) The Oregon Health Authority shall adopt by rule the procedures for distributing to hospitals the moneys described in section 9 (2)(d), chapter 736, Oregon Laws 2003, to ensure that such moneys are distributed as follows:

(a) The authority shall distribute 50 percent of the moneys based upon each hospital's:

(A) Compliance with data submission requirements; and

(B) Achievement of the performance standards recommended by the hospital performance metrics advisory committee under subsection (3) of this section.

(b) The authority shall annually distribute the remainder of the moneys to coordinated care organizations based upon recommendations made by the metrics and scoring [*committee*] **subcommittee**.

SECTION 14. (1) Subject to any prior approval that may be required by the Centers for Medicare and Medicaid Services, the Oregon Health Authority, the Department of Consumer and Business Services, the Oregon Educators Benefit Board and the Public Employees' Benefit Board shall implement the health outcome and quality measures described in ORS 413.017 (4) on and after January 1, 2018.

(2) The members of the Health Plan Quality Metrics Committee shall be appointed no later than February 1, 2017.

SECTION 15. Section 1, chapter 608, Oregon Laws 2013, as amended by section 6, chapter 16, Oregon Laws 2015, and section 13 of this 2015 Act, is repealed on September 30, 2019.

SECTION 16. Section 1 of this 2015 Act is repealed on January 2, 2021.

SECTION 17. The amendments to ORS 243.135, 243.866, 413.011, 413.017, 413.032, 413.181, 414.025, 414.638, 414.679 and 417.721 and section 1, chapter 608, Oregon Laws 2013, by sections 2 and 4 to 13 of this 2015 Act become operative February 1, 2017.

SECTION 18. The Oregon Health Policy Board, the Oregon Health Authority, the Department of Consumer and Business Services, the Oregon Educators Benefit Board and the Public Employees' Benefit Board shall take any action before the operative date specified in section 17 of this 2015 Act that is necessary for the boards, the department and the authority to exercise, on and after the operative date specified in section 17 of this 2015 Act, all of the duties, functions and powers conferred on the boards, the department and the authority by the amendments to ORS 243.135, 243.866, 413.011, 413.017, 413.032, 413.181, 414.025, 414.638, 414.679 and 417.721 and section 1, chapter 608, Oregon Laws 2013, by sections 2 and 4 to 13 of this 2015 Act.

SECTION 19. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.
